Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2023

Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, MN 55912

RE: CCN: 245447
Cycle Start Date: July 13, 2023

Dear Administrator:

On September 21, 2023, we notified you a remedy was imposed. On September 27, 2023, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 18, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 13, 2023, did not go into effect. (42 CFR 488.417 (b))

In our letter of August 18, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 13, 2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 18, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 18, 2023

Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, MN 55912

RE: CCN: 245447
Cycle Start Date: July 13, 2023

Dear Administrator:

On July 13, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 October 13, 2023, (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).

In addition, if substantial compliance with the regulations is not verified by January 13, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245447	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/13/2023

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245447	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/13/2023

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a written notice of transfer was provided for 1 of 1 resident (R13) reviewed who was hospitalized on an emergent basis.

Findings include:

R13's significant change Minimums Data Set (MDS) assessment dated 6/7/23, included intact cognition.

A progress note dated 3/26/23 at 9:30 p.m., indicated R13 was transferred via ambulance to the local hospital. The medical record lacked evidence of a written notice of transfer being offered or provided to the resident and/or the resident representative. The resident returned to the facility on 4/11/23.

During interview on 7/10/23 at 3:39 p.m., R13 indicated he had never received anything in writing about the transfer prior to his transfer to the hospital.

During interview on 7/12/23 at 9:35 a.m., licenses practical nurse (LPN)-A indicated the facility verbally tell the resident and the family member regarding transfer but do not give anything in writing. LPN-A indicated the only thing given in writing is a bed hold form.

During interview on 7/12/23 at 9:50 a.m., LPN-B indicated nothing is given in writing to the resident and family regarding transfers. The only thing given to the resident and family is a bed hold form.

During interview on 7/12/23 at 11:40 a.m., the director of nursing (DON) indicated agreement is made with the resident and family prior to discharge but confirmed there is no transfer notice in writing given to the resident.

During interview on 7/12/23 at 2:45 p.m., social services (SS)-A indicated she is not aware of a written transfer notice being given in writing but is notifying the ombudsman monthly of those discharged and transferred out of the facility.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 A policy and procedure was requested and none was received.
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R13) or legal representatives reviewed for hospitalizations had been informed of bed hold rights at the time of transfer/discharge to hospital. Findings include: R13's face sheet printed 7/13/23, indicated diagnoses including disruption of wound, fracture of neck, kidney disease, type II diabetes mellitus, and heart failure. R13's significant change Minimum Data Set (MDS) assessment dated 6/7/23, indicated R13 had intact cognition, is understood and understands and exhibited no behaviors. A progress note dated 3/26/23 at 9:30 p.m., indicated R13 was found lying on his left side with a one centimeter dehiscence (surgical wound splits open) with bleeding noted to surgical wound. R13's medical record lacked documentation of bed hold written notification given to resident or family member. A progress note dated 3/26/23 at 10:26 p.m., indicated a family member (FM) was notified of the resident's change in condition and transfer to the emergency department.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245447	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/13/2023

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 3

During interview on 7/10/23 at 3:39 p.m., R13 indicated he does not believe he was asked about a bed hold or given anything written on bed holds when transferred to the hospital.

During interview on 7/12/23 at 11:29 a.m., licensed practical nurse (LPN)-B indicated the facility sends a bed hold form with the resident to the hospital along with a transfer form that includes the residents medical information and medical records. Families are notified by telephone. Upon request to view the bed hold form sent with a resident, a Bed-Hold Notice at the Time of Transfer policy and procedure was received. LPN-B stated they must be out of bed hold forms in the drawer.

During interview on 7/12/23 at 10:38 a.m., the director of nursing (DON) indicated there was no signed bed hold completed for R13 and confirmed there was no evidence in the medical record of notification of a bed hold. The DON added this is something that needs to be "tightened up" to ensure residents receive the bed hold notification.

During interview on 7/12/23 at 2:45 p.m., social services (SS)-A indicated at the time of R13's transfer the clinical managers were taking care of ensuring the resident and/or family received a bed hold. SS-A indicated the process has changed since to her completing the bed holds when on site and the nurses sending the bed hold and policy with them to the hospital when she is no on site. SS-A indicated the bed hold likely was not competed at that time.

The facility Bed Hold policy dated 6/18/21, included:
-If the social worker is available at the time the resident is transferred to the hospital, the social worker will be e responsible for the bed hold discussion and giving a copy of the policy to the resident or resident's representative.
-The social worker will have the resident or resident's representative sign a Notice of Bed Hold Form (which will go on the patient's paper chart under misc.) and chart a progress note of the notification.
-If it is determined the bed hold notice needs to be given to the resident's representative, and the individual is not present at transfer to the hospital, the social worker will call the resident's representative to discuss, mail a copy of the bed hold policy to the individual, and chart a progress note.
-If the social worker is not present during the resident's transfer to the hospital, nursing will be responsible to speak to the resident or resident's representative, along with giving a copy of the bed hold policy.

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 _____	C 07/13/2023

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
E 000	Initial Comments On 7/10/23 through 7/13/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	. EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:	E 039		9/7/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2023

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
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E 039	Continued From page 1 (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:	E 039		

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 _____	C 07/13/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 2 (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or	E 039		

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 _____	C 07/13/2023

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E 039	Continued From page 3 man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 4 required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency	E 039		

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	245447	A. BUILDING _____ B. WING _____	C 07/13/2023

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E 039	Continued From page 5 event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise	E 039		

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E 039	Continued From page 6 following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based	E 039		

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E 039	Continued From page 7 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or	E 039		

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E 039	Continued From page 8 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:	E 039		

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E 039	Continued From page 9 (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure emergency preparedness (EP) exercises, including an internal exercise, a community based, or full scale exercise and another full scale community based exercise or a table top exercise were completed annually to test their emergency preparedness plan. This had the potential to affect all 52 residents residing in the facility. Findings include: The emergency preparedness binder dated 2/10/23, had no documentation of EP exercises for 2022 or 2023. During an interview on 7/13/23, at 10:30 a.m., the administrator indicated the last emergency exercises that could be located were from 2021. The administrator was uncertain if a table-top or community full scale based exercise had been completed over the past year but could not find any documentation that they were completed. A review of emergency preparedness policy and procedures did not include required emergency	E 039	Sacred Heart Care Center participated in a community base table top exercise on 9/7/2023. On 9/18/2023 Sacred Heart will be participating in the SEMN Coalition full scale community exercise. Annually the Administrator will participate and facilitate emergency preparedness exercises for Sacred Heart Care Center. The Safety Officer will facilitate emergency drills as required annually and this will be audited by the Administrator.	

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E 039	Continued From page 10 drills.	E 039		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the	E 041		9/6/23

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E 041	Continued From page 11 Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012	E 041		

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E 041	Continued From page 12 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9, 8.4.9.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 7/11/2023 between 9:00 a.m. and 2:00 p.m., it was revealed during documentation review that documentation presented for review did not confirm that once every 36 months - 4 hour continuous run of the emergency generator is occurring.	E 041	9/6/2023 the Environmental Services Director and contractor successfully completed the 4 hour load test of the generator. Contractor installed wiring to hook a rental generator to the building if power is lost for longer than 4 hours. Annually, the Administrator will audit records of the generator.	

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E 041	Continued From page 13 An interview with the Maintenance Director verified this deficient finding at the time of discovery. During interview on 7/13/23 at 10:30 a.m., the administrator stated they had hired a company to come and test the generator and was unsure why they only did the run for 3 hours versus 4 hours. The administrator indicated she would be contacting the company to verify the times the generator was actually run.	E 041		
F 000	INITIAL COMMENTS On 7/10/23 through 7/13/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued. H54473171C (MN94118) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		9/8/23

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F 584	Continued From page 14 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 15 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to ensure a comfortable environment, having hot water available for 2 of 2 residents (R3, R21), who were reviewed for concerns with cold water to resident bathroom sinks. Findings include: R3's quarterly Minimum Data Set (MDS) assessment, dated 6/10/23, indicated intact cognition and required extensive assistance by 1 staff for personal hygiene cares. R3's care plan indicated washes face and hands after given a prepared cloth, staff completes bathing including peri-area, partial bed bath on alternate days. R21's significant change in status MDS assessment, dated 7/5/23, indicated intact cognition and required extensive assistance by 1 staff for personal hygiene cares. R21's care plan indicated washes face and hands after given a prepared cloth, staff completes bathing including peri-area. During observation and interview on 7/10/23 at 2:24 p.m., R21 indicated did not have hot water to bathroom sink since admission to facility on 4/19/23, stated would like bathroom sink to have warmer water, warm water unavailable due to room being at end of hallway. R21 indicated staff aware hot water to bathroom sink was cold and	F 584	Water temperatures are being checked daily. If water is not in the comfortable temp range, water is brought in from a different source in the range. Sacred Heart is receiving bids to replace the boilers in the building to solve the periodical lack of comfortable water. On-going environmental services will be checking water temps daily. Education provided to Environmental Services on daily water temp logs and legionella testing. Sacred Heart is in the processes of purchasing new boilers for the building. Staff educated to report when something is "wrong" with resident room water to Env Services. Env. Services will contact outside vendor to assist in fixing the water. Env Services will document tap water temperatures in 6 resident rooms per week / per wing. The director of Env Services will review documentation weekly to look for discrepancies. Boilers were fixed and provide hot water to all residents. R3 and R21 are receiving hot water. Maint. increased the thermostats. If the water is cold again, residents will be moved from the end rooms and the rooms will not be occupied until the problem is fixed.	

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F 584	Continued From page 16 remains cold.. Surveyor noted water to R21's bathroom sink initially cold when turned on, remained cool after running hot water for 10 minutes. During an observation and interview, on 7/10/23 at 2:37 p.m., R3 indicated hot water in her bathroom sink was cold, stated water should be warm when staff assist with bathing and personal hygiene cares. R3 indicated hot water in bathroom sink had been cold for approximately 6 months, had informed staff of concerns, maintenance had looked at hot water temperature to bathroom sink on several occasions,. R3 stated hot water to bathroom sink remains cold. Surveyor noted water to R3's bathroom sink was initially cold when turned on, hot water ran for 10 minutes, temperature of hot water ran after 10 minutes increased to luke-warm. While interviewed, on 7/12/23 at 7:49 a.m., nursing assistant (NA)-C indicated awareness of hot water to R3 and R21's bathroom sinks being cold, had been a concern for approximately 2 months. NA-C stated she had informed nursing staff of cold-water concerns to R3 and R21's bathroom sinks, maintenance requested to further evaluate hot water temperature to R3 and R21's bathroom sinks, hot water to R3 and R21's bathroom sinks remained cold. NA-C indicated would try to run R3 and R21's hot water to bathroom sinks for approximately . 15-20 minutes prior to personal hygiene and bathing cares, as water would get warmer. NA-C stated hot water to R3 and R21's bathroom sinks occasionally had remained cooler temperature after running water for 15-20 minutes, would then go to other resident rooms on unit to get hot water for R3 and R21's	F 584		

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F 584	Continued From page 17 personal hygiene and bathing cares. During an interview, on 7/12/23 at 7:58 a.m., NA-D indicated awareness hot water to resident bathroom sinks were unavailable to all residents on unit, affected mainly residents that resided at end of hallway on unit, R3 and R21 bathroom sinks. NA-D stated unavailability of hot water to resident bathroom sinks had been a concern since NA-D started working at facility approximately. 9 months ago, had brought concerns to nursing staff's attention, was informed per nursing staff to let water run for a while as would eventually become warm. NA-D indicated would run water for a while, occasionally hot water would still be cold, would then go to other resident rooms on unit to get hot water for R3 and R21's personal hygiene and bathing cares. While interviewed, on 7/12/23 at 8:32 a.m., with maintenance director (M)-A, indicated working for facility for 2 years, was a licensed nurse, and recently took over maintenance director position. M-A stated duties included daily check of temperatures for boilers and tanks, valve checks, performing monthly water temperatures to resident rooms. M-A indicated awareness of abnormal water temperatures to boilers, storage tanks, and to various resident rooms, stated some residents' bathroom sinks did not have hot water available. M-A indicated nursing staff had brought to her attention of abnormal water temperatures to resident bathroom sinks, abnormal water temperature throughout entire facility had been a concern for past 2 years, during time had tried adjusting valves to increase water temperature to residents' bathroom sinks. M-A stated had contacted Harty Mechanical,	F 584		

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F 584	Continued From page 18 plumbing/heating/air company, for further evaluation of facility's abnormal water temperatures several months ago, confirmed had not contacted any water/plumbing/heating companies recently with known continued abnormal water temperatures and should have. M-A verified facility did not have interventions for correcting abnormal water temperature in place at time and should have. During an interview, on 7/12/23 at 9:10 a.m., administrator confirmed awareness of abnormal water temperatures within facility, stated had an assessment completed per Harty Mechanical on 6/15/23, informed boilers for hot water were the original boilers placed when facility was built and needed replacement, as well as hot water pumps needed to be replaced. Administrator verified facility did not have interventions for correcting abnormal water temperatures in place at time, in process of applying for assistance with state for financial grant to assist with building expansion project. Facility policies for home-like/comfortable environment and water temperatures was requested, but not received.	F 584		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	F 661		9/8/23

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F 661	Continued From page 19 (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an appropriate discharge summary had been completed for 1 of 1 resident (R51) who was discharged to home. Findings include: R51's face sheet, printed 7/13/23, identified R51 was admitted to the facility on 3/9/23, with diagnosis including pneumonia, pulmonary fibrosis (lung disease that causes scarring and thickening of the tissue around the air sacs) and rheumatoid arthritis. R51's progress note dated 4/14/23 at 10:10 a.m., identified R51 was discharged to home on 4/14/23 at 10:10 a.m. via private transportation	F 661	Recapitulation was done immediately upon knowledge of R51 - who was discharged home. Sacred Heart now has 3 RN's doing due RAI process and recapitulations. The Clinical Managers will audit discharges weekly. Sacred Heart has increased the Clinical Manager team from 1 person to 3 people to share the work load. Clinical Managers have been educated on recapitulation requirements and will review all discharging residents. Clinical Managers audited all charts to ensure recapitulation was completed.	

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F 661	Continued From page 20 with son. R51 left in a wheelchair from the wing, but left wheelchair at the front door. R51 took front wheeled walker and medications with her. R51 also took a portable oxygen tank and will return to facility once oxygen supplies delivered to home. A discharge note dated 4/12/23 at 11:07 a.m., identified R51 as alert and oriented with a brief interview for mental status (BIMS) score of 10 indicated moderate impairment. Resident scheduled to discharge to her home on 4/14/23. R51 stated she will have a helper for her laundry, cleaning her apartment, and getting her to medical appointments. R51 is interested in Meals on Wheels. Family member or helper will help R51 pack her pill packs. R51 stated if she has to use oxygen at home, she will use it. A progress note dated 4/13/23 at 10:36 p.m., indicated R51 was alert, pleasant and cooperative. Oxygen was being titrated down as possible and currently on 0.5 liters per minutes via nasal cannula. R51 is able to use her call light and communicate needs. R51 is independent with transfers in room and to her bathroom. Eats and drinks per self and ate 100% of supper meal after tray set up. No cough, congestion, shortness of breath or edema noted. No discharge summary that included a recapitulation of R51's stay and a final summary of R51's status at the time of discharge was found in the medical record. During interview on 7/13/23 at 9:18 a.m., registered nurse (RN)-D indicated the recapitulation is done electronically in the medical record and after review indicated this one wasn't	F 661		

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F 661	Continued From page 21 completed. RN-D added looks like this one was missed. During interview on 7/13/23 at 9:40 a.m., the director of nursing confirmed the recapitulation was not completed and should have been. The facility Discharge and Transfer Documentation policy dated 2/6/14, included: -We will provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility -Documentation will include who was instructed in resident's care -Discharge summary must include date/time of transfer, reason for transfer, diagnoses and condition at time of discharge. -A post discharge plan of care with the participation of the resident and his/her family which assist the resident to adjust to her/her living environment will be completed. -A recapitulation of the resident's stay must be completed within five days of discharge. Final summary of resident's status that includes items at the time of discharge that is available to authorized persons and agencies with the consent of the resident or legal guardian.	F 661		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		9/8/23

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F 688	Continued From page 22 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to reassess residents for restorative services and provide restorative services to maintain and/or prevent loss of range of motion (ROM) with and without contractures for 3 of 3 residents (R9, R35 and R16) reviewed for limited ROM. Findings include: R9's facesheet printed on 7/13/23 included diagnoses of cerebral infarction (stroke), generalized muscle weakness, arthritis of both shoulders, dementia, and Alzheimer's disease. R9's annual Minimum Data Set (MDS) assessment dated 5/17/23, indicated severe cognitive impairment. R9 who did not walk, required extensive assistance or was totally dependent upon one or two staff for all activities of daily living (ADLs). R9's physician orders and care plan did not include or identify restorative nursing services or ROM exercises. During an interview on 7/10/23 at 5:19 p.m.,	F 688	Upon identification R16 was assessed and added to the range of motion program. R35 is receiving therapy services and therapy reviewed ROM program and restorative. Therapy reviewed and updated R9's ROM program and restorative program. Upon admission all residents, including those on hospice, will be reviewed for contractures and need for range of motion and restorative services. All hospice admissions and current residents will be assessed and added to the range of motion program by therapy. Clinical Managers will audit charting that therapy has assessed every resident for range of motion up on admission. Blue Stone Therapy has joined Sacred Heart, replacing Integrated Therapy. Education with therapy to review ROM and restorative programs on all residents. Clinical Managers will review and audit charting for ROM and restorative services. Therapy will assess all new admissions for ROM and restorative program.	

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F 688	Continued From page 23 family member (FM)-C stated she did not know if R9 received ROM exercises or therapy, adding, "I sure hope he is getting it." FM-C stated R9 had left-sided weakness since his stroke and was not able to move on his own, adding R9 needed exercises to avoid stiffness in his joints. R9 was observed in his wheelchair, not speaking, or moving during interview with FM-C. During an interview on 7/11/23 at 2:39 p.m., nursing assistant (NA)-A stated she did not provide ROM exercises to residents and was aware of only one person, (NA)-B, who provided restorative nursing services to residents. During an interview on 7/11/23 at 2:48 p.m., in the rehab (rehabilitation) department, NA-B stated she had been providing restoratives nursing services at the facility for years and was currently the only employee providing the services. NA-B stated restorative services stopped during the Covid-19 pandemic and just recently started up again with NA-B resuming services in May of this year. NA-B stated she had received training for the role of restorative aide years ago. NA-B stated she does ROM for R9 on the days she worked which were Tuesday, Thursday, and Friday one week and Tuesday, Wednesday, Friday, Saturday, and Sunday the next week. NA-B stated she was usually able to provide restorative services to all residents who needed it each day she worked. NA-B stated she performed R9's ROM in the morning while he was in bed, doing ROM to both his upper and lower extremities. NA-B was not able to provide documentation of the specific restorative recommendations from OT (occupational therapy) and/or PT (physical therapy), stating, "I just know what I'm supposed to do." When asked	F 688		

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F 688	Continued From page 24	F 688		

to see her documentation of the ROM exercises she provided to R9, NA-B picked up an iPad, pressed some buttons and set the iPad down without displaying documentation.

During an interview on 7/11/23 at 3:04 p.m., licensed practical nurse (LPN)-C who was also the clinical manager for the wing on which R9 resided, was not aware of a specific restorative nursing program for R9, but provided printed documentation from the electronic medical record (EMR) of restorative services provided to R9 in June and July. LPN-C stated the documentation was entered into the EMR by NA-B.

Review of documents indicated R9 received restorative services on the following dates:
--In June, bilateral lower extremity and bilateral upper extremity ROM was provided on only three days: 6/13/23, 6/15/23 and 6/16/23.
--In July, bilateral lower extremity and bilateral upper extremity ROM was provided on only three days: 7/8/23, 7/9/23 and 7/11/23.

Along with the documentation provided by LPN-C was a document indicating R9 was to have "rehab 5 days/week." LPN-C did not know how or who determined the frequency and admitted rehab 5 days a week was not realistic with only one restorative aide providing the service. LPN-C stated the facility had been looking to build the restorative nursing program, but staffing was a challenge. LPN-C stated she was not aware of R9's specific restorative nursing recommendations, including frequency, but stated they could be found in R9's hard chart.

During record review in R9's hard chart, two paper documents both titled PT/OT/Speech

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F 688	Continued From page 25 Recommendations were found. One was dated 10/17/17, and one dated 12/23/16. Both addressed R9's restorative program recommendations. Based upon R9's current condition, he would not have been able to perform the program as indicated in 2016 and 2017, such as standing and a riding stationary bike. No recommendations were found for R9's current restorative program (PROM exercises) being performed by NA-B. R35's facesheet printed on 7/13/23 included diagnoses of Parkinson's disease and Alzheimer's disease. R35's quarterly MDS assessment dated 6/7/23, indicated intact cognition. R35 had clear speech, could understand others, and was usually understood. R35 required extensive assistance of two staff for all ADL's, except could eat independently. R35's CAA (Care Area Assessment) dated 12/21/22, for ADL functional and rehabilitation potential indicated R35 had impaired sitting, standing balance, incomplete performance, needed verbal cues, sequencing problems, history of right hip and femur fracture. R35's physician orders dated 7/7/22, indicated to ensure R35 used stationary pedal bike in his room everyday x 10 minutes. R35's care plan dated 10/11/21, indicated impaired mobility related to poor balance and coordination due to Parkinson's disease and history of right hip and femur fracture. Interventions included to walk with FWW (forward wheeled walker) with assist of two staff, twice a	F 688		

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F 688	Continued From page 26 day. The care plan did not include restorative services. During an interview on 7/10/23 at 3:42 p.m., in R35's room with FM-E present, FM-E stated the facility used to have a restorative program, but with the Covid pandemic, it ended. Finally, after many months, FM-E stated R35 was now supposed to receive restorative services three days a week, however it had not been three days a week for over a month. FM-E stated the facility had only one staff member providing restorative services. FM-E stated she wanted R35 to maintain balance and ROM of joints and did not want R35 to lose mobility due to Parkinson's -- adding he had been doing so well for so long. R35, who was sitting in a wheelchair next to FM-E stated yes, when asked if he agreed with FM-E. FM-E stated she recently filed a formal grievance with the facility after speaking to the DON and administrator about this and seeing no changes. Facility grievances were reviewed. One dated 7/6/23 from FM-E indicated, "lack of consistent therapy (restorative). Affects mental and physical well-being. Lack of exercise causes decrease in muscle tone. Has talked to administrator, DON and SW. Recently three weeks has passed with no changes and no therapy of restoration. Residents decline with lack of. Concerned we aren't getting help to maintain levels." During an interview on 7/11/23 at 2:55 p.m., NA-B stated she did quite a bit with R35. NA-B stated R35 was brought to the rehab department for restorative services which included cane exercises, upper and lower extremity bike, reaching for cones, standing at paralleled bar, and kicks with weights. NA-B stated R35	F 688		

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F 688	Continued From page 27 tolerated it well and he liked doing it. NA-B stated on her days off or when on vacation, restorative services were not provided to residents. NA-B was not able to provide documentation of the specific restorative recommendations from OT and/or PT, stating, "I just know what I'm supposed to do." When asked to see her documentation of the ROM exercises she provided to R35, NA-B picked up an iPad, pressed some buttons and set the iPad down without displaying documentation. During an interview on 7/11/23 at 3:04 p.m., licensed practical nurse (LPN)-C who was also the clinical manager for the wing on which R35 resided, was not aware of a specific restorative nursing program for R35, but provided printed documentation from the electronic medical record (EMR) of restorative services provided to R35 in June and July. LPN-C stated the documentation was entered into the EMR by NA-B. Review of documents indicated R35 received restorative services on the following dates: --In June, dowel exercise, upper extremity cycling, seated cone exercise, stand at rail, strengthening exercises with weights, was provided on only three days: 6/13/23, 6/15/23 and 6/16/23. --In July, dowel exercise, upper extremity cycling, seated cone exercise, stand at rail, strengthening exercises with weights, was provided on only three days: 7/8/23, 7/9/23 and 7/11/23. Along with the documentation provided by LPN-C was a document indicating R35 was to have "rehab 5 days/week." LPN-C did not know how or who determined the frequency and admitted rehab 5 days a week was not realistic with only	F 688		

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F 688	Continued From page 28 one restorative aide providing the service. LPN-C stated the facility had been looking to build the restorative nursing program, but staffing was a challenge. LPN-C stated she was unaware of R35's specific restorative nursing recommendations, including frequency, but stated they could be found in R35's hard chart. During record review in R35's hard chart, there was one document titled PT/OT/ST (speech therapy) Recommendations to Nursing, dated 7/7/22. This document indicated use of a floor bike in R35's room each day for 10 minutes. The document also indicated R35 should remain on the walk list. These activities were completed by NA's working on the unit where R35 resided. There was no documentation regarding the restorative nursing program NA-B had been providing to R35 such as dowel exercise, upper extremity cycling, seated cone exercise, stand at rail, and strengthening exercises with weights. During an interview on 7/13/23 at 8:15 a.m., the DON was informed of findings: 1) restorative services had been provided to R9 and R35 without PT and/or OT recommendations, and 2) restorative services had not been provided on a regular and consistent basis according to documentation provided by LPN-C. The DON was aware of and acknowledged R9 and R35 had not received restorative nursing services on a regular and consistent basis. According to the DON, providing restorative services to residents had been difficult due to having only one employee providing the service. The DON stated the facility had planned to hire and train additional staff, but that had not occurred yet. The DON acknowledged the importance of a restorative program to assess residents for limitations of	F 688		

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F 688	Continued From page 29 ROM and provide services to improve and/or maintain joint mobility. Further, the DON stated rehab services had recently changed to a new company and was aware documentation from the previous company had not been available. A facility policy on restorative services was requested, and the DON stated the facility did not have one. R16's significant change in status MDS assessment, dated 6/9/22, indicated severely impaired cognition, no behaviors, no rejection of cares. R16 had functional limitations in ADLs and required total assistance from 2 staff with bed mobility, transfers, toileting, total assistance of 1 staff with eating, locomotion on and off unit, and for personal hygiene. R16 had impairment of left upper and lower extremity, did not ambulate, used a wheelchair for mobility. The MDS further indicated R16 had medically complex conditions, diagnoses included, atrial fibrillation (irregular heartbeat), heart failure (HF), arthritis (inflammation, pain, stiffness of joints), hemiplegia/hemiparesis (paralysis), and depression (mood disorder). R16's admission face sheet printed 7/12/23, listed additional diagnosis to include, obesity, chorea (involuntary muscle movements). R16's client coordination note, dated 5/18/22, indicated was evaluated per provider for nursing home placement, was receiving hospice services and required higher level of skilled nursing care than could be met at place resided. Client coordination note further indicated R16 had suffered a cerebral vascular accident ((CVA), stroke), which resulted in left-sided weakness,	F 688		

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F 688	Continued From page 30 functional decline/debility, left hand tremor, and left foot disorder of muscle tone with contracture. R16's order summary report, printed on 7/12/23, indicated orders for OT to evaluate and treat. R16's care plan, reviewed on 6/14/23, indicated broda chair for positioning, footrests on broda wheelchair at all times. Review of progress notes, indicated on 6/9/23, R16 had graduated from hospice and a significant change in status MDS assessment was completed, functional status was assessed and no changes from baseline. Progress notes indicated on 6/20/23, nursing staff contacted R16's family member for approval to receive OT services, orders requested and approved per provider. Progress notes further indicated on 7/11/23, orders requested and approved per provider for bilateral hand rolls from morning AM till 3 PM daily, watching for redness. Review of OT Evaluation and Plan of Treatment note, dated 6/26/23, indicated an initial assessment of musculoskeletal system, R16 had functional limitations to bilateral hands due to contracture. An assessment of bilateral lower extremities, with known left foot contracture, was not noted. Review of OT Treatment Encounter Note, indicated on 6/26/23, staff forgot to apply hand rolls, OT educated staff on importance of donning (applying) hand rolls and following wear schedule. OT Treatment Encounter Note, dated 6/30/23, indicated staff did not don R16's hand rolls in morning per wear schedule, OT to train staff on appropriate wear schedule for hand rolls and	F 688		

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F 688	Continued From page 31	F 688		

importance of compliance with schedule. OT Treatment Encounter Note, dated 7/3/23, indicated staff did not don R16's hand rolls in morning per wear schedule, OT completed caregiver training and education with staff on importance of donning hand rolls and following wear schedule. OT Treatment Encounter Note, dated 7/5/23, indicated R16 had hand rolls donned at time of visit.

During an observation and interview, on 7/10/23 at 3:50 p.m., R16 observed to have all fingers of R16's bilateral hand curled inward towards palm of hand, skin to bilateral palm of hand slightly reddened, skin intact, roll/splint to bilateral hand not noted at time of observation. R16's bilateral foot was observed to be covered with socks, resting on elevated footrests. Bilateral foot visualized as stiff, rigid, and flexed inwards. Right foot slightly flexed inwards, left foot observed to be moderately flexed inwards, brace/splint to bilateral foot not in place at time. R16 indicated staff apply hand rolls to bilateral hand for support, although not applied consistently by staff daily, stated did not have any brace/splint for bilateral foot, was working with OT.

While interviewed, on 7/11/23 at 1:06 p.m., NA-E indicated had worked at facility for 2.5 yrs., was aware of R16's care needs, stated care needs could be found in care plan, NA daily task assignment check off in point click care (PCC) electronic medical record (EMR) system, and NA resident information sheet. NA-E indicated awareness of contracture to bilateral hand and foot, stated R16 had blue hand rolls to be applied to bilateral hand during day, at night would float bilateral foot on cushion. NA-E indicated unawareness of any brace/splint application to

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F 688	Continued From page 32 bilateral foot, not aware of any therapy exercises nursing staff were responsible to ensure completion of, stated PT working with R16. During an interview, on 7/11/23 at 1:37 p.m., LPN-A indicated had worked at facility for 15 years aware of R16's care needs, stated care needs could be found in care plan and in PCC. LPN-A indicated R16 had contracture of bilateral hand and foot since admission to facility, stated R16 recently graduated from hospice approximately 1 month ago. LPN-A indicated cares for R16's contracture to bilateral hand consisted of applying palm protectors, was not aware of any braces/splints for bilateral foot or restorative therapy exercises in place at time. LPN-A reviewed R16's care plan and orders in PCC, verified R16 did not have treatment orders to address contracture of bilateral hand and bilateral foot noted in PCC, care plan, or in R16's hard chart when reviewed. LPN-A stated R16 had been working with OT, staff were informed of treatment needs per OT, staff were to apply hand rolls to bilateral hand in morning and remove in afternoon. LPN-A indicated when residents received therapy services, if therapy staff wanted nursing to complete any treatments for residents, therapy staff would verbally discuss orders wanted for therapy treatment with charge nurse, charge nurse would communicate resident therapy needs with staff during shift and again with staff at shift report, and charge nurse would place a note in PCC communication tab of resident new orders. LPN-A stated therapy staff would also provide a copy of facility Rehab Communication form to unit case manager (CM) for order entry. While interviewed, on 7/12/23 at 8:47 a.m.,	F 688		

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F 688	Continued From page 33 occupational therapy assistant (OTA)-F indicated had evaluated R16 on 6/26/23, confirmed contracture to bilateral hand, ordered to continue to wear palm protectors. OTA-F stated therapy orders for R16's bilateral hand palm protectors had been communicated verbally with nursing staff. OTA-F indicated R16's Rehab Communication form with written treatment orders was provided to nursing staff, unable to locate form at time. OTA-F stated had not evaluated R16's contracture of bilateral foot, PT managed. During an interview, on 7/12/23 at 8:50 a.m., PT-G indicated awareness R16's contracture to bilateral hand and left foot, had not assessed contracture as was on hospice. PT-G stated awareness R16 had recently graduated from hospice, therapy staff do not automatically assess residents when graduating from hospice to determine need for therapy services, nursing staff to notify therapy department if noticing resident needed therapy evaluation based on nursing assessment findings. PT-G confirmed R16 had not been evaluated per PT department for any contracture in last 2 months. While interviewed, on 7/12/23 at 10:26 a.m., RN-D, also known as unit CM, indicated R16 was admitted to facility with contracture of bilateral hand and left foot, was receiving hospice services at time of admission until approx. 1 month ago when graduating from hospice. RN-D stated R16 had a significant change of condition MDS assessment completed due to graduating from hospice, assessment completed on 6/9/23. RN-D indicated when R16's nursing assessment was completed on 6/9/23, nursing staff would have assessed contracture of bilateral hand and left	F 688		

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F 688	Continued From page 34 foot, nursing staff would have requested OT/PT evaluation at time. RN-D stated remembering a discussion had with nursing staff regarding R16's contracture to bilateral hand and left foot, and need for OT/PT services, not sure if follow-up from discussion occurred. RN-D confirmed after review of R16's medical record, a request was made for OT evaluation on 6/20/23, request for PT evaluation missed and will follow-up on. During an interview, on 7/12/23 at 12:53 p.m., the DON indicated R16 was transferred from an assisted living facility (ALF) to skilled nursing facility (SNF) over a year ago as R16's medical condition had been declining and required increase in skilled nursing cares, R16 was on hospice and had bilateral palm protectors at time of SNF admission, but unknown for provision of bilateral palm protectors. The DON indicated R16's medical condition improved, graduating from hospice services in May '23, and a significant change in condition assessment was completed 6/9/23. The DON stated nursing assessments were completed for residents at time of admission, quarterly, change in condition, and at time of discharge; nursing assessments included review of resident's functional limitation, including history of contracture. The DON indicated any concerns identified or restorative services to be implemented, nursing staff should request an evaluation from therapy department. The DON verified upon R16's medical record review, nursing requested OT evaluation on 6/20/23, nursing had not requested PT evaluation and should have. The DON confirmed since time of R16's admission to facility, R16 did not have orders for use of bilateral palm protectors until 7/12/23.	F 688		

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F 688	Continued From page 35 The facility Contracture Management policy reviewed last on 7/12/23, indicated to maintain optimum level of resident comfort in the presence of contracture. Licensed nursing staff, with input from the NAs, will assure residents with contractures are positioned and receive care to maintain mobility to the affected joint. Procedure: Recommend PT and OT evaluation if the safety of the procedure is questionable, or if further consultation is needed to position a severely contracted limb(s). Contracture of Hand (Fingers): Clean hand with soap and water at least daily, dry well. Trim fingernails closely and keep clean, (Moisture collection and long nails may result in breakdown of skin and infection). Check hand daily for odors and breakdown of skin. Place a clean hand roll in the hand daily/or apply splint. ROM and/or restoration devices per PT recommendations and/or MD orders. Maintain cleanliness of splint or device. Scheduled removal of device will be maintained per physician order.	F 688		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		9/6/23

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F 761	Continued From page 36 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) 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 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 and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 1 refrigerators and emergency kit (E-kit) observed for medication storage. This had the potential to affect all residents in the facility. Findings include: During tour of the facilities only medication room on 7/12/23 at 9:30 a.m., licsensed practical nurse (LPN)-B entered the medication room without use of key. LPN-B indicated the ice machine is in this room so the room is not locked. LPN-B opened the refrigerator with one key. Inside the refrigerator were 7 square metal boxes with a key lock on the top. LPN-B removed each metal box from the refrigerator and opened each without using a key. LPN-B indicated they aren't locked even though a lock is present. LPN-B attempted using a key to try to lock them, but no key on her key ring worked. In 5 of the metal containers, a liquid bottle of lorazepam intensol (benzodiazepine used to treat seizures, decrease	F 761	Sterling Long Term Care Pharmacy came to the facility and secured 3 metal boxes to the fridge. The medication fridge is also secured with a lock. The schedule 2 fridge medications are stored in the lock box in the fridge. Charge nursing staff will audit that the e-kits have not been opened daily. DON, will audit e-kits charting monthly that they are not opened daily and match the eMAR for use. Nursing staff have received education on the practice of locking the medications in the fridge. Residents have not been impacted by the deficient practice Staff have been educated on locking the medication room door	

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F 761	Continued From page 37 anxiety) 2 mg/ml (a schedule IV, controlled medication) was present. The metal containers containing lorazepam were labeled with residents name, which included R14, R19, R20, R47 and R10. LPN-B confirmed the lorazepam medications are not double locked in the refrigerator. An emergency kit (e-kit) was in a metal wall unit and double locked. LPN-B indicated the pharmacy restocks, reconciles and ensures medications are present in the e-kit. If nurses use medications out of the e-kit, they are responsible for faxing a form to the pharmacy for notification. This form includes resident name, date of birth and physician along with medication used and nurses signature, date and time. Also included was red tag number taken off and red tag nurse used to reseal the kit. LPN-B indicated nursing staff are not reconciling the e-kit. The pharmacy is responsible and she was unsure how often they come if the kit is not used. The Emergency Medication Kit Reorder form included the following medications: -Morphine 20mg/ml oral syringes 0.5 ml (10mg) each. -Hydromorphone 2 mg tablet -Oxycodone 5 mg tabs (immediate release). During observation and interview on 7/12/23, at 9:42 a.m., the director of nursing (DON) entered the medication room without a key and confirmed the entrance door is not locked. the DON confirmed their is only one lock to access the lorazepam (controlled medication) stored in the refrigerator as the metal containers are not locked nor are they affixed to the refrigerator. The DON opened the door for the e-kit which was double locked. There were 2 tackle boxes present and both had a yellow numbered tag	F 761		

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F 761	Continued From page 38 present securing them. The DON confirmed controlled substances are present in one of the e-kits and staff only go into the locked cupboard if they need to take something out of one of the kits. The DON indicated pharmacy is responsible to reconcile if the e-kit has been accessed and what medications are present or missing. The DON confirmed the pharmacy only comes approximately monthly to do this. During interview on 7/12/23 at 11:14 a.m., the consulting pharmacist (CP)-A indicated, the nursing staff should check to ensure e-kits have not been opened daily and to minimally ensure a yellow tag is intact on each e-kit. The facility Provider Pharmacy Requirements policy undated, indicated the provider pharmacy is responsible for providing, maintaining, and replenishing an emergency medication supply in a sealed and properly labeled container in a timely manner.	F 761		
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food brought in from home was dated and stored separately from facility food for 2 of 2 residents (R32, R202) reviewed for food storage. Findings include:	F 813	Purchase of fridge for resident use. Audits will be conducted on the wing fridges and resident use fridge for facility/resident/personal fridge use and dates and labeled. Audits will be submitted monthly for review. Charge nursing staff will facilitate the audits on	9/6/23

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F 813	Continued From page 39 During an interview on 7/12/23 at 2:21 p.m., dietary manager (DM)-A stated the facility did not encourage food to be brought in from home for residents and did not have a designated refrigerator for this purpose. DM-A stated if food was brought in from home for residents, it might be stored in refrigerators located in the nurses stations. During observations on 7/13/23 at 10:25 a.m., observations were made of dormitory-sized refrigerators in each of the three nurses stations. --Wing 2 refrigerator had facility food and beverages in it, such as juice and applesauce. Also observed were two small plastic containers of food. One container had a hand-written note taped to the lid which indicated, "R32, 117 for supper. Mac Salad." The container contained a bow-tie pasta salad. There was no date on the container indicating when it was brought to the facility. Another plastic container had a typed address label affixed to the lid indicating R202's name, spouse's name, and address. Inside the container were two boiled eggs and pieces of cooked bacon. There was no date on the container indicating when the food was brought to the facility. Registered nurse (RN)-B stated food brought in from home should be labeled with the date it was brought to the facility and acknowledged the containers had not been dated. RN-B stated she would throw the food away. In addition, there was a jar of pickles and a sealed bag of baby carrots in the refrigerator without names; RN-B thought they belonged to residents. Further, RN-B had a personal plastic container of egg salad in the refrigerator and removed it, stating she was aware staff food should not be in the refrigerator with resident food	F 813	random shifts for the next two months. Audits will be brought to the QAPI team to review. Staff education provided in regards to food storage for residents and personal use. All food brought into the facility will be labeled and dated by the wing nurse or food service manager and placed in the fridge for resident use. Rescinded from the policy, the hand-written statement. Resident and facility food will not be stored in the same refrigerator. Residents with personal food was labeled and stored separately.	

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F 813	Continued From page 40 and beverages. --Wing 3 refrigerator had facility food and beverages in it. Also observed was a clear, plastic disposable container with a piece of pie in it, without a name or date. In addition, there were Snickers brand candy bars, a box of Turtle brand candies and a container of Ferrero Rocher brand candies -- all with resident names on them. Further, there was a large bottle of a sports drinks in the refrigerator which (RN)-A stated belonged to a staff person. During an interview on 7/13/23 at 10:35 a.m., registered nurse (RN)-C who was also the infection preventionist, was informed of food brought in from home and staff food and beverages in refrigerators on wings 2 and 3. RN-C stated food brought in from home needed to be labeled with a residents name and date and should not be stored with facility food due to potential food safety issues. Further, RN-C stated staff were not permitted to store food in refrigerators on the nursing units. During an interview 7/13/23 at 10:41 a.m., the administrator stated if food was brought from home for a resident, it was likely stored in refrigerators on the nursing units or in the kitchen. Informed of findings in the refrigerators in the nurses station on wings 2 and 3 and of the regulation that food brought in from home needed to be dated and not stored with facility food. The administrator stated, "I get that and understand why" due to potential food safety concerns. The administrator had been unaware this had been taking place and stated she would discuss it with the leadership team. During an interview on 7/13/23 at 10:56 a.m.,	F 813		

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	245447	A. BUILDING _____ B. WING _____	C 07/13/2023

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F 813	Continued From page 41 DM-A was informed of findings in refrigerators on the nursing units. DM-A stated the facility had been planning a remodel of the dining area and she had asked for space for residents and families to store food from home. DM-A stated the remodeling project would not occur for a while and therefore would need to figure something out in the meantime for storage of food brought in from home. The facility Food from Outside Sources policy dated 2008, indicated food from outside sources was discouraged due to problems with food safety and infection control. All food brought in was to be checked by the charge nurse or food service manager and placed in a plastic container with a tight-fitting lid. Food brought in would be labeled with the individual's name and dated if it needed to be stored. Added to the policy in handwriting: Homemade food would be stored on the wing (nursing units) and not in the kitchen.	F 813		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		9/14/23

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F 880	Continued From page 42 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 43 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to adequately follow water management program to consistently monitor water temperatures and implement corrective action when water temperatures were out of range for Legionella (a bacteria causing pneumonia and flu-like symptoms) prevention, which had the potential to affect all 52 residents residing within facility. Findings include: On 7/12/23 at 10:44 a.m., during observation and interview of boilers/storage tanks completed with maintenance (M)-A; temperature to boiler #1- 175 degrees Fahrenheit (F), temperature to boiler #2- 205 degrees F, temperature to storage tank #1- 144 degrees F, temperature to storage tank #2- 114 degrees F. M-A indicated water was heated from boilers and passed to storage tanks, storage tank #1 to have a temperature maintained at 180 degrees F, tank #2 to have a temperature maintained at 115 degrees F. Record review of facility temperature checks to boilers and storage tanks, reviewed from	F 880	Education provided to Environmental Services on daily water temp logs and legionella testing. Sacred Heart is in the processes of purchasing new boilers for the building. Staff educated to report when something is "wrong" with resident room water to Env Services. Env. Services will contact outside vendor to assist in fixing the water. Env Services will document tap water temperatures in 6 resident rooms per week / per wing. The director of Env Services will review documentation weekly to look for discrepancies.	

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F 880	Continued From page 44 1/1/23-7/12/23, indicated inconsistent completion of daily temperature checks and abnormal temperature ranges. Daily temperature checks to boilers and storage tanks was observed completed 12 out of 31 days for Jan/23, 7 out of 28 days for 2/23, 1 out of 31 days for 3/23. No record of daily temperature checks to boilers and storage tanks were noted for months 4/23, 6/23, 7/23. During review period from 1/23-3/23, maintained temperature for tank #1 ranged from 140-170 degrees F, maintained temperature for tank #2 ranged from 110-112 degrees F. Record review of facility monthly water temperatures of resident rooms, reviewed from 1/4/23-6/14/23, noted to have hot water temperatures ranging from 79-118 degrees F. During an interview, on 7/12/23 at 8:32 a.m. with maintenance director (M)-A, indicated working for facility for 2 years, was a licensed nurse, recently took over maintenance director position. M-A stated was a part of water management team, duties included daily check of temperatures for boilers and tanks, valve checks, performing monthly water temperatures to resident rooms, ensuring flushing of toilets, and running showers to resident rooms not used, ensuring ice machine and drinking fountains are deep cleaned and filters changed every 6 months. M-A indicated awareness of abnormal water temperatures to boilers, storage tanks, and to various resident rooms, stated some residents' bathroom sinks did not have hot water available. M-A indicated abnormal water temperatures had been a concern for past 2 years, during time had tried adjusting valves to increase water temperature to acceptable range, stated acceptable temperature range to reduce growth of Legionella needed to	F 880		

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F 880	Continued From page 45 be between 106-108 degrees. M-A confirmed had not reviewed water management plan for acceptable water temperature controls, unaware of resources provided in facility water management plan could refer to, stated previous maintenance director drew line to mark appropriate temperature range for boilers and storage tanks for M-A to rely on. M-A indicated contacting Harty Mechanical, plumbing/heating/air company, for further evaluation of facility's abnormal water temperatures several months ago, confirmed had not contacted any water/plumbing/heating company recently with known continued abnormal water temperatures. M-A unaware of any Legionella testing performed within facility, verified facility did not have interventions for correcting abnormal water temperature in place at time and should have. While interviewed, on 7/12/23 at 9:10 a.m., administrator confirmed awareness of abnormal water temperatures within facility, stated had an assessment completed per Harty Mechanical on 6/15/23, informed boilers for hot water were the original boilers placed when facility was built and needed replacement, as well as hot water pumps needed to be replaced. Administrator unaware of Legionella testing performed within facility, verified facility did not have interventions for correcting abnormal water temperatures in place at time, in process of applying for assistance with state for financial grant to assist with building expansion project. The facility Sacred Heart Care Center Water Management policy dated 7/21, indicated to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in its building water systems through the	F 880		

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F 880	Continued From page 46 development and implementation of water management program and consisted of: -Key elements of a water management program included identifying areas where Legionella could grow and spread, decide where control measures should be applied and how to monitor them, establish ways to intervene when control limits are not met, make sure the program is running as designated and is effective, document and communicate all related activities. -Water management team members may contact other individuals, as needed, for their expertise in water management. This may include representatives of: Equipment or chemical suppliers, City of Austin water department, Environmental health specialists, Minnesota Department of Health. -A number of factors are required to increase the risk of acquiring Legionellosis (pneumonia type disease caused by Legionella bacteria), namely: condition of the water and existence of suitable conditions for the organism to grow and multiply in the storage and distribution systems, i.e. water temperatures between 77-108 degrees Fahrenheit, and a source of nutrients, e.g. organic matter such as sludge, scale, rust, or algae; the presence of people to expose, particularly the vulnerable such as residents of a nursing home, a means of creating a aerosol or small breathable droplet such as from a shower, the presence of bacteria. -Centers for Medicare and Medicaid Services (CMS) has identified the following as possible control measures in a water management program: physical controls, temperature	F 880		

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F 880	Continued From page 47 management, disinfectant level control, visual inspections, and environmental testing for pathogens. With the exception of testing for pathogens, Sacred Heart Care Center uses the other control methods. -In all cases, when staff or residents notice that something is "wrong" (temperature, color, smell) with the facility's water, the Environmental Services Supervisor will be notified and will investigate to determine the cause of the problem, will contact appropriate professionals, if needed, to resolve the problem. Maintenance documents monthly the water temperature at the tap in six resident rooms on each of the three nursing wings, is reviewed and would investigate any discrepancies from the 105-115-degree range required by the Minnesota Department of Health.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's 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 representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		9/6/23

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F 883	Continued From page 48 documentation that indicates, at a minimum, the following: (A) That the resident or resident's 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. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's 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 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 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 883	Mayo Senior Services will review all	

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F 883	Continued From page 49 facility failed to provide evidence pneumococcal vaccinations were up to date for 4 of 5 residents (R11, R20, R22, R28, R202) reviewed for vaccinations. Findings include: R11's quarterly Minimum Data Set (MDS) assessment, dated 5/10/23, indicated an admission date of 10/4/21, was 88 years of age, had moderately impaired cognition, updated pneumococcal vaccination status had not been assessed. The MDS further indicated R11's diagnoses included Alzheimer's disease (brain disorder causing memory loss/mental impairment), heart failure, and renal insufficiency (kidney impairment). R20's significant change in status MDS assessment, dated 5/26/23, indicated an admission date of 12/12/22, was 92 years of age, had moderately impaired cognition and medically complex health conditions, updated pneumococcal vaccination status had not been assessed. The MDS further indicated R20's diagnoses included congestive heart failure (CHF), renal insufficiency, Alzheimer's disease, chronic pulmonary edema (swelling of lung). R22's quarterly MDS assessment, dated 5/10/23, indicated an admission date of 10/17/22, was 62 years of age, had severely impaired cognition and medically complex health conditions, updated pneumococcal vaccination status had not been assessed. The MDS further indicated R22's diagnoses included epilepsy (seizure disorder), peripheral vascular disease (abnormal circulation of blood vessels to arms/legs), and neurogenic bladder (bladder dysfunction).	F 883	residents vaccine records upon admission and required visits. They will be administered by Sacred Heart Care staff after obtaining vaccination orders. The infection control RN will review resident vaccination status annually at time of fall vaccinations. Upon admission, case managers will audit vaccination status. Medical Records will review current resident records for vaccination status and will audit vaccination status moving forward. Nursing staff will review and vaccinate residents that are no currently up to date in the within the next two weeks. The four residents identified were vaccinated for pneumococcal.	

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F 883	Continued From page 50 R28's quarterly MDS assessment, dated 6/28/23, indicated an admission date of 4/25/22, was 93 years of age, had intact cognition and medically complex health conditions, updated pneumococcal vaccination status had not been assessed. The MDS further indicated R28's diagnosis included chronic kidney disease. R202's admission MDS assessment, dated 7/12/23, indicated an admission date of 7/12/23, was 93 years of age, had intact cognition and medically complex health conditions, updated pneumococcal vaccination status had not been assessed. The MDS further indicated R202's diagnoses included cancer and renal insufficiency. During an interview, on 7/13/23 at 8:23 a.m., registered nurse (RN)-C, also infection control preventionist (ICP), indicated managing review of immunizations for influenza and Covid-19, rounding nursing home physician manages review of all other immunizations including pneumococcal. RN-C stated recent awareness of residents not being up to date on pneumococcal vaccinations, was brought to her attention approximately 1 week ago per nursing staff rounding nursing home physician indicated had not been reviewing residents' vaccination status, rounding nursing home physician thought facility nursing staff were managing all resident vaccination needs. RN-C indicated management of resident's vaccinations will be discussed with rounding nursing home physician at next visit, will plan to review all residents' vaccination records, provide any needed immunizations to residents including pneumococcal; ensuring all residents' vaccination status is up to date.	F 883		

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F 883	Continued From page 51 While interviewed, on 7/13/23 at 10:01 a.m., the director of nursing (DON), indicated resident's immunization status was reviewed upon admission, provider visits, and as needed. DON stated licensed nursing, including case managers (CMs), and rounding nursing home physicians were responsible for reviewing immunization status to ensure up to date. DON confirmed ineffective communication amongst facility staff and rounding nursing home physician regarding management of resident's immunization status, will plan to further discuss responsibility and management of residents' immunization with facility staff and rounding nursing home physician to correct. The facility Pneumococcal policy undated, indicated all residents will be offered the appropriate pneumococcal vaccine to aid in preventing infection. Policy interpretation and implementation consisted of: 1. Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax (pneumococcal vaccine), and when indicated, will be offered the vaccination unless medically contraindicated or the resident has already been vaccinated. 2. Assessments of pneumococcal vaccination status will be conducted within thirty (30) working days of the resident's admission if not conducted prior to admission. 3. Before receiving the Pneumovax, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record.	F 883		

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F 883	Continued From page 52 4. Pneumococcal vaccinations will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. 5. Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. 6. For residents who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. 7. Administration of the pneumococcal vaccination or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination. 8. Inquiries concerning our facility's policies governing pneumococcal vaccinations should be referred to the Infection Control Coordinator or Director of Nursing Services.	F 883		

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	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/11/2023. At the time of this survey, SACRED HEART CARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. SACRED HEART CARE CENTER is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 with partial basement and was determined to be of Type II(111) construction. In 1997, addition was constructed with partial basement and was determined to be of Type II(111) construction. In 2007, and addition of four rooms were added to the 300 wing of the building and was determined	K 000		

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K 000	Continued From page 2 to be of Type II (111) construction. 2-hr fire rated wall(s) separate the Nursing Home from Adult Day Care and Assisted Living Commons. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors 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 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,	K 324		8/25/23

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K 324	Continued From page 3 or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and inspect the kitchen, ansul type, fire suppression system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5, 19.3.2.5.1 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed during documentation review that no documentation was present to confirm that the kitchen, ansul type, fire suppression system is being inspected every six months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	Documentation located - semiannual 5/31/23 Keep documentation accessible for surveys	

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K 353	Continued From page 4	K 353		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3.1, 4.3.2, 4.3.3, 5.1.1.1, 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed during documentation review that	K 353	Documentation found: Q1: 1/4/22 & 1/6/23 Q2: 4/5/22 & 4/20/23 Q3: 7/6/22 & 7/12/23 Q4: 10/4/22 Keep documentation available for survey	8/25/23

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K 353	Continued From page 5 no documentation was present to confirm that the sprinkler system quarterly inspection, for the 2nd quarter of 2023, had been completed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353		
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.3, 7.2.4.4, 7.2.4.5, 7.3.1.1.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed during documentation review that monthly manual inspections records were missing initials of person performing the inspection 2. On 07/11/2023 between 9:00 AM and 2:00 PM,	K 355	Completed Signature and line added to the bottom of the document and initial added each month Keep receipt from Austin Fire & Safety	8/25/23

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K 355	Continued From page 6 it was revealed during documentation review that there were annual inspections records presented for review for the fire extinguishers inspected, including those found to require corrective action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly secure electrical panel(s) per NFPA 101 (2012 edition), Life Safety Code, section 19.5.1.1, 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.27. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed by observation that an electrical panel in the Wing 3 corridor was found to be	K 511	Took keys out, labeled, and locked	8/25/23

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K 511	Continued From page 7 unsecured and readily accessible to unqualified individuals 2. On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed by observation that two electrical panels in the Core Area of the facility were found to be unsecured and readily accessible to unqualified individuals. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 511		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 914		8/25/23

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K 914	Continued From page 8 by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2.1 to 6.3.3.2.4, 6.3.4.1.3, 6.3.4.2.1.1, 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed during documentation review that documentation presented for review was incomplete in-that forms were not dated or signed, and testing results for each individual outlet was not documented. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	Paperwork changed to include dates, signatures, and each outlet per line	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		8/25/23

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K 918	Continued From page 9 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9, 8.4.9.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed during documentation review that documentation presented for review did not confirm that once every 36 months - 4 hour continuous run of the emergency generator is	K 918	Receiving bids for new generator.	

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K 918	Continued From page 10 occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of flexible cords and cables in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section	K 920	Done 10 foot power strip	8/25/23

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K 920	Continued From page 11 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have widespread impact on the residents within the facility. Findings include: 1. On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed by observation that in the RN Office, relocatable power taps were daisy-chained together. 2. On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed by observation that in the Clinical Manager Office, an appliance was connected to a relocatable power tap. 3. On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed by observation that in Activities Assistant Office - located in the Core Area, and extension cord was found supply power to a relocatable power tap. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	Education to staff that appliances must be plugged directly into the wall. Moved office spaces, no longer require extension cords.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or	K 923		8/25/23

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K 923	Continued From page 12 limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 5.1.3.3.2, 5.1.3.3.3, 9.3.7, 9.3.7.5.3, 11.3, 11.3.1, 11.3.2, 11.5.2.2. These deficient findings could have a widespread impact on the residents within the facility.	K 923	Cardboard boxes were removed. Two baskets were placed on shelf for items. Checked fan on roof. It is running. When it is quiet, you can hear fan running.	

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K 923	Continued From page 13 Findings include: 1. On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed by observation that the Med Gas (O2) Storage Room had storage of cardboard boxes next to Liquid Oxygen Cylinders. 2. On 07/11/2023 between 9:00 AM and 2:00 PM, it was revealed by observation that it could not be confirmed that the exhaust fan was operational in the Med Gas (O2) Storage. An interview with the Facility Director verified these deficient findings at the time of discovery.	K 923		