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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5QF9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00452

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245454**
2.STATE VENDOR OR MEDICAID NO.
(L2) **475213900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER**
(L4) **109 COURT AVENUE SOUTH**
(L5) **SANDSTONE, MN** (L6) **55072**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/31/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Patricia Halverson, Unit Supervisor — 12/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/31/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245454

December 2, 2014

Ms. Jamie Paro, Administrator
Essentia Health - Sandstone Medical Center
109 Court Avenue South
Sandstone, Minnesota 55072

Dear Ms. Paro:

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

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

Effective October 10, 2014 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 2, 2014

Ms. Jamie Paro, Administrator
Essentia Health - Sandstone Medical Center
109 Court Avenue South
Sandstone, Minnesota 55072

RE: Project Number S5454024

Dear Ms. Paro:

On September 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 11, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On October 31, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 11, 2014, effective October 10, 2014 and therefore remedies outlined in our letter to you dated September 22, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5454r15

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245454	A. Building B. Wing	10/31/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER	109 COURT AVENUE SOUTH SANDSTONE, MN 55072

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **10/10/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/10/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/30/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/01/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/24/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PLH/mm	12/02/2014	12835	10/31/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/11/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5QF9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00452

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(L1) **245454**
2.STATE VENDOR OR MEDICAID NO.
(L2) **475213900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER**
(L4) **109 COURT AVENUE SOUTH**
(L5) **SANDSTONE, MN** (L6) **55072**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/11/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Cheryl Johnson, HFE NEII 10/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 10/29/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6924

September 22, 2014

Ms. Jamie Paro, Administrator
Essentia Health - Sandstone Medical Center
109 Court Avenue South
Sandstone, Minnesota 55072

RE: Project Number S5454024

Dear Ms. Paro:

On September 11, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Patricia.halverson@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 11, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 11, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5454s14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER	109 COURT AVENUE SOUTH SANDSTONE, MN 55072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (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. CENSUS: 41	F 000	OK 10/5/14 PCH	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**F280** **Element #1** Resident R46 was reassessed for moods and behaviors and care plan was updated to reflect consistent refusal of care. This was completed on 9/11/2014. **Element #2** All other residents had the potential to be affected by the deficient practice. The Resident Services Coordinator reviewed all care plans for accuracy. **Element #3** To prevent this from happening again, education was provided in the 9/19/2014 weekly news publication "Friday Notes" about how	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janice Peters, RN/mha	LTC Administrator	10/1/2014

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
	245454	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER	109 COURT AVENUE SOUTH SANDSTONE, MN 55072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to address refusals related to nail care, taking medications, and getting out of bed for 1 of 1 resident (R46) reviewed for activities of daily living. Findings include: On 9/8/14, at 5:21 p.m. R46 was observed in the room in bed. When R46 attempted to speak there was a foul odor noted coming from the mouth, and there were dried flecks of a white substance R46's lower lip. R46's fingernails on the right hand were long with brown debris beneath. The toenails on the right foot (exposed from under the bedding) were jagged and very long. On 9/8/14, from approximately 4:00 p.m. to 8:00 p.m. R46 refused to get out of bed on the afternoon shift. On 9/10/14, at 7:34 a.m. R46 refused his insulin medication and refused to get out of bed. On 9/11/14, at approximately 7:30 a.m. R46 refused all medications. On all days R46's toenails remained very long, and the fingernails also remained long with brown debris under the nails. R46 refused to allow surveyor observation of personal care. The activities of daily living (ADL) assistance care plan reviewed 6/30/14, indicated R46 required extensive to total assist for all ADL's due to a stroke, lethargy, and pain. The care plan	F 280	to report moods and behaviors. Staff was provided additional training on 9/30/2014 on how to report behaviors. The DON attended annual training for our Achieve Matrix electronic medical record from 9/21/2014-9/25/2014. There are new updates available that allow nursing assistants the ability to document Moods/behaviors with a text box to explain the specific mood/behavior that occurred. This task will be assigned to nursing assistants to complete each shift for every resident. This new upgrade provides a more efficient method for documenting moods/behaviors. Nursing staff will be updated at the mandatory meeting on 9/30/2014 and given additional instruction on how to enter behaviors into the Electronic Medical Record. **Element #4** To maintain accurate care plans, 1 care plan will be reviewed by direct care staff on each station each day for accuracy. The Resident Services Coordinator will review all documentation and update mood/behavior notes on a monthly basis for those residents receiving psychotropic medications. The DON or designee will conduct 5 audits on mood/behavior tracking each month x 3 months, then quarterly x 3 months, than as needed based upon findings.	

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F 280	Continued From page 2 indicated R46 had natural upper and lower teeth and often refused oral cares. The care plan directed staff to re-approach if R46 refused oral care, and attempt to swab the mouth with toothettes every two hours. The care plan further directed staff to complete diabetic nail care on bath days, and to assist the resident into the wheelchair at least twice a day. The care plan did not address R46 consistently refused nail care, taking medications, or to get out of bed. ~~On 9/11/14, at 3:00 p.m. the director of nursing~~ (DON) confirmed she was aware R46 consistently refused cares, and verified the care plan was not revised to address the additional refusals.	F 280	Negative findings will be reported at the quarterly QAPI meetings. **Element #5** The facility will be in full compliance with F309 by 10/10/2014.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure pressure relieving intervention were provided as directed by the care plan for 1 of 3 residents R32 who were reviewed for pressure ulcers. Findings include: R32's admission record dated 7/18/14, indicated diagnoses that included a hip fracture, atrial fibrillation, osteoporosis, hypertension, pulmonary	F 282	**F282** **Element #1** Resident R32 was re-issued an air mattress. The air mattress is designed specifically to reduce pressure to heels. She is no longer care planned to have heels floated. **Element #2** There were eleven additional residents that had the potential to be affected by the deficient practice. **Element #3** Staff were educated through the 9/19/2014 weekly news publication "Friday Notes" reminding staff about floating heels "Float Heels" was changed to bold font on the nursing assistant assignment sheet. The	

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F 282	Continued From page 3 emboli and falls. The admission Minimum Data Set (MDS) dated 7/28/14, indicated R32 received hospice care, had severe cognitive impairment and required the extensive assistance of two staff with bed mobility and transfers. The MDS also indicated R32 was at risk for pressure ulcers and had one stage two (partial thickness loss of the dermis presenting as a shallow open ulcer). The MDS indicated skin and ulcer treatments included a pressure reduction mattress on the bed, a turning and repositioning program and the application of ointment or medication to an area other than the feet. The skin care plan with a problem start date of 7/18/14, directed staff to float heels off the bed. The undated nursing assistant (NA) assignment sheet directed staff to float the heels off the bed. During constant observation on 9/10/14, from 7:15 a.m. to 10:10 a.m. R32's feet were turned out with the heels on the mattress and no device to float the heels off of the mattress. During the observation time R32 was repositioned side to side with the heels on the mattress. On 9/10/14, at 10:12 a.m. the care plan was reviewed with registered nurse (RN)-A. RN-A verified the care plan stated to float heels off of the bed. R32's heels were observed with RN-A and found to have no redness, pain or impairment. The RN stated R32's heels should have been floated.	F 282	facility conducted a root cause analysis on why this error occurred. We were able to conclude that because this intervention relied upon staff to remember to do something, there would always be a potential for the error to re-occur. After working with our vendors, we were able to find a honeycomb pressure reducing device that could be placed at the foot of the bed under the fitted sheet. Because of its pressure reducing ability, the heels no longer need to be floated. This option also decreases the risk of skin breakdown on the toes or calves, which can be a negative problem with heel floating. **Element #4** To maintain compliance with F282, the DON or designee will conduct audits to ensure that the new honeycomb sheets are in place for those residents who are care planned for them. This will be done monthly x 3 month, then quarterly x 3 quarters, then on an as needed basis depending upon compliance. **Element #5** The facility will be in full compliance by 10/10/2014.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	**F431**	

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F 431	Continued From page 4 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication labels were accurate to reflect the current route of	F 431	**Element #1** To correct the deficient practice of inaccurate medication labels, a change of direction sticker was added to each of the medication blister packs for R28 and R46. The pharmacy has updated the orders for both residents as well as added warning notes to their prescription profiles to alert staff when entering new orders that all meds are via tube. This will help to be an additional safety check on these residents. **Element #2** There were no other residents that could be affected by the deficient practice at this time. **Element #3** The pharmacy was contacted on 9/12/2014 to begin a root cause analysis on how this error occurred. The error seems to have occurred by the nursing staff as well as pharmacy staff. Pharmacy staff has been re-educated to seek clarification for all conflicting medication orders. Nursing staff were educated on 9/30/2014 about the 5 rights of medication administration including verifying the correct route. **Element #4** The pharmacy nurse consultant will monitor the accuracy of medication labels each month for those residents that receive their medications	

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F 431	Continued From page 5 administration (gastric tube) for 2 of 2 residents (R46, R28) who received nothing by mouth (NPO). Findings include: R46 was observed during a medication pass on 9/10/14, at 7:34 a.m. The licensed practical nurse (LPN)-B administered all medications via a gastric tube (PEG). The labels on the medications directed staff to administer as follows: hydralazine 25mg one tab orally QID (four times a day) lisinopril 20mg orally daily metroprolol 100mg tabs give 1 1/2 tabs (150mg) orally twice a day (BID) The electronic medication administration record (EMAR) directed hydralazine and lisinopril by gastric tube and metroprolol orally. In another area the EMAR directed, "All meds and nutrition via G-tube - NPO." LPN-B confirmed the medication labels directed to administer the medications orally and verified R46 was to receive nothing by mouth (NPO). LPN-B stated when orders change or labels are incorrect an order change sticker should have been applied to the medication labels, and the pharmacy should have been notified so the labels could have been corrected. Current physician's orders dated 8/18/14, directed staff to administer all medications crushed via the gastric tube with water. The order initially started 3/20/14. On 9/11/14, at 9:30 a.m. the director of nursing (DON) verified R46 was unable to take any food	F 431	via enteral tube. All negative findings will be reported to the quarterly QAPI meetings. **Element #5** The facility will be in full compliance on 9/30/2014.	

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F 431	Continued From page 6 or fluids orally, and confirmed all medication labels should include the correct route of administration. R28 was observed during a medication pass on 9/11/14, at 8:10 a.m. LPN-B administered all medications via a feeding tube. Pharmacy labels on the medications directed vitamin D3 1000 u orally every day and warfarin (Coumadin) (a medication used to thin the blood) 5 mg 1&1/2 tablets (7.5 mg) orally on Monday and Friday and one tablet (5mg) orally on Sunday, Tuesday and Wednesday, Thursday and Saturday. The EMAR dated 9/1/14 through 9/11/14 directed aspirin and Coumadin orally. Another area of the EMAR directed "NPO (nothing by mouth) status, administer all medications through the MIC tube." LPN-B verified the labels directed oral medications although R28 was NPO. The current physician's orders signed on 7/2/14, indicated R28 had a NPO status. Tube feeding and all medications were to be given via the MIC tube.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	**F441** **Element #1** The NAR that made the error was coached regarding her performance with glove use, hand washing, handling soiled linen and disposing of infectious material. She was able to verbally state where she made errors and steps she should have	

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F 441	Continued From page 7 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to to ensure appropriate infection control standards were implemented for equipment sanitation for residents (R33, R7) hand hygiene for residents (R7, R32), and linen and infectious waste handling for resident (R7). This had the potential to affect all 41 residents who resided in the facility.	F 441	taken to minimize the spread of infection. **Element #2** All residents of the facility had the potential to be affected by the violation. **Element #3** All staff received additional education regarding glove use, timing of hand hygiene, handling of infectious waste and handling of soiled linen through the 9/19/2014 weekly news publication "Friday Notes". They were also educated on these topics at the mandatory meeting on 9/30/2014. Nurses were re-educated using a demonstration on how to properly clean the glucometer. Additionally, a third glucometer was ordered to minimize the transfer of the meter from one nurse to another for testing. This minimizes the overall risk for transmission of infectious material. **Element #4** The Infection Control nurse or designee will conduct audits each month of infection prevention measures. Audits will cover glove use, hand hygiene, handling of infectious waste, handling of soiled linen and glucometer cleaning. Audits will be completed monthly x 3 months, then quarterly x 3 months. Negative findings will be reported at the QAPI meetings.	

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F 441	Continued From page 8 Findings include: R7's face sheet indicated diagnoses which included diabetes, dementia, urinary tract infection. Physician progress notes dated 7/27/14, indicated further diagnoses of recurrent urinary tract infections and neurogenic bladder (dysfunction of the bladder's ability to empty). R7's quarterly Minimum Data Set (MDS) dated 8/12/14, identified moderate cognitive deficit (memory loss), required extensive assistance of two staff for bed mobility, dressing, and personal hygiene; and use of Foley catheter. R7's physician orders dated 8/31/14, included doxycycline (antibiotic) 100 milligrams (mg) twice daily for 7 days in response to a urine culture dated 8/28/14, with results that indicated methicillin-resistant staphylococcus aureus (MRSA) infection. R7's care plan dated 5/7/14, indicated the presence of MRSA in the urine and directed urine to be carried covered and dumped in the hopper room. The undated nursing assistant sheets indicated R7 had MRSA in the urine and urine was to be carried covered and dumped in the hopper. The catheter was to be emptied every hour. The NA sheets also indicated R7 required limited assist with care of personal areas of the body and assistance with dressing. During care observed on 9/10/14, at 7:10 a.m., nursing assistant (NA)-C donned gloved, applied protective cream to the buttocks with the right gloved hand, removed the glove from the right hand, pulled the pants up with the right hand, picked up a pink bin with the empty catheter bag	F 441	**Element #5** The facility will be in full compliance with F441 on 10/01/2014.	

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F 441	Continued From page 9 in it, and opened up the room blinds using both hands. Without gloves on either hand, NA-C picked up loose linen and two garbage bags in addition to the bin with the catheter bag. NA-C opened the bathroom door, then the bedroom door, walked next door to open the soiled linen room. NA-C placed the bin with the catheter bag on the shelf and sorted the loose soiled laundry into bins. NA-C took the bin with R7's catheter bag and walked to the soiled utility room, opened the door, put the catheter bin on top of a shelf and put the garbage away before washing hands in the soiled utility room. At 7:25 a.m., NA-C stated linens were sorted into bins with towels and out-sourced laundry separated from personal laundry. NA-C also verified she should have washed her hands after providing personal care for R7 and before touching other things and leaving the room. At approximately 10:00 a.m., NA-C did not don gloves before going into R7's bathroom to remove a plastic garbage bag from the a graduate used toempty and measure R7's urinary catheter output. NA-C explained she had used the graduate to measure the urine, dumped the urine into the shared toilet, and placed the contaminated graduate on a shelf next to the sink in the shared bathroom. During an interview on 9/10/14 at 10:40 a.m. with the director of nursing (DON), she verified hand washing or sanitizing should be done before entering and leaving the resident's room, before and after touching residents or providing cares, and between dirty and clean tasks. The DON further indicated hands should be washed or sanitized after removing gloves and before touching anything else, and if hands are visibly dirty, they need to wash hands with soap and water, instead of sanitizer.	F 441	**(This page intentionally left blank)**	

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F 441	Continued From page 10 On 9/11/14, at 9:33 a.m. NA-C verified she carried the NAR sheet in her pocket when doing cares on 9/10/14, and had not noted the directive to dump the urine for this resident in the hopper. During an Interview with the infection preventionist (IP) on 9/11/14, at 10:58 a.m., she stated once a resident has had MRSA, they are always treated as if they have MRSA. The IP stated the expectations were to wash hands after removing gloves and verified linens are to be separated and put in separate bags in the room, and then taken in the bags to the soiled linen room and placed in the appropriate bin. The IP also verified the graduate for measuring urine that has MRSA in it, is not to be stored in the shared bathroom, and should be for single-use only and should be thrown after it is used when the bathroom is shared. In addition, the urine was not to be dumped in the toilet in a shared bathroom when there is MRSA, but was to be dumped in the hopper. The facility policy and procedure for hand hygiene revised 3/14, directed hand hygiene to be performed after body fluid exposure risk, after touching a patient, after touching patient environment, and before and after glove use. The facility policy and procedure for standard precautions and personal protective equipment revised 3/14, directed gloves are to be worn whenever hand contact with blood, body fluids, or blood/body fluid contaminated surfaces is anticipated. It further directed hand hygiene to be performed between patient contacts, after touching body fluids and contaminated items, and immediately after removing gloves. In addition,	F 441	**(This page intentionally left blank)**	

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F 441	Continued From page 11 laundry and linen was to be handled in a manner that prevents transfer of microorganisms to others and the environment. The facility policy and procedure for laundry/linens management revised 5/09, directed soiled laundry was to be placed in a linen bag at point of origin and placed in a soiled utility room for pick-up. On 9/10/14, at 11:34 a.m., licensed practical nurse (LPN)-B, was observed during a glucometer (machine used to check blood sugar levels) check on R33. After LPN-B obtained the blood sample with the glucometer, she placed it on the medication cart and removed her gloves. LPN-B picked up the glucometer, placed it on the other medication cart, documented the findings on the computer, and then sanitized her hands. LPN-B, then picked up the glucometer, brought it to the nurse's desk and set it down, opened the glucometer supply box, and removed a package with a sani-cloth, germicidal wipe and opened it. LPN-B cleaned the glucometer with the sani-cloth. During an interview on 9/10/14, at 11:40 a.m. LPN-B verified she should have cleaned the glucometer right after using it and before setting the glucometer down. During an observation on 9/10/14, at 11:44 a.m. LPN-D performed a blood sugar check with the glucometer on R7. After obtaining the blood sample in the strip inserted in the glucometer, LPN-D set down glucometer on the medication cart and read the result. LPN-D picked up the glucometer and set it down on another part of the medication cart, removed her gloves, sanitized	F 441	**(This page intentionally left blank)**	

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F 441	Continued From page 12 her hands, and put on new gloves. LPN-D carried the glucometer to the nurse's desk while wiping it with alcohol wipes, set it down on the desk, opened glucometer supply box, cleaned glucometer with more alcohol wipes, set in the glucometer supply box and removed her gloves. During an interview on 9/10/14 at 11:58 a.m., LPN-D verified she should have washed the glucometer off prior to setting it down. LPN-D also verified she always uses alcohol wipes to clean the glucometer. During an interview on 9/11/14, at 10:58 a.m., the IP verified glucometers were to be cleaned after each use with Sani-wipes and not alcohol wipes. In addition, the IP verified the expectation is to clean the glucometer immediately after discarding the strip after taking the sample, and before setting the machine down, or to set it on a barrier if they do set it down. The facility policy and procedure for glucose monitoring care and procedure revised 7/13, directed the entire glucometer was to be wiped with a damp Sani-Cloth and allowed to dry well between patients. R32's admission record dated 7/18/14, indicated diagnoses that included a hip fracture, atrial fibrillation, osteoporosis, hypertension, pulmonary emboli and falls. The admission Minimum Data Set (MDS) dated 7/28/14, indicated R32 was under Hospice care, had severe cognitive	F 441	**(This page intentionally left blank)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER	109 COURT AVENUE SOUTH SANDSTONE, MN 55072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 impairment and required the extensive assistance of two staff with bed mobility and transfers and total assistance of one staff with dressing and personal hygiene. R32 was observed on 9/10/14, at 11:05 a.m. when nursing assistant (NA)-A provided incontinence care. NA-A removed the brief and cleaned the peri area and buttock of incontinent stool. With the same gloved hands, NA-A rolled R32 toward her, lowered bed with the bed controls, wiped the buttocks again, removed gloves and donned new gloves without washing or sanitizing her hands. NA-A applied a white colored cream to R32's peri area and buttocks and changed gloved, again without hand washing, and helped R32 with her pants. NA-A changed gloves again without hand washing, emptied R32's catheter bag into a graduate, emptied the graduate into the toilet, and removed her gloves. NA-A left room without washing or sanitizing her hands. NA-A returned to R32's room, lowered bed with the controls, left again without washing or sanitizing her hands and returned with the hoyer lift. NA-A donned a glove on the right hand and applied lotion to R32's back, removed the glove, and placed the the lift sling under R32. NA-A retrieved R32's chair from outside the room and transferred R32 into the chair. NA-A removed the lift from the room to the hall, gathered the trash and soiled linen and exited the room without washing or sanitizing her hands. NA-A went to the soiled utility room opening the door with the door knob. On 9/10/14, at 11:35 a.m. NA-A stated she was told it was optional but should have the hand sanitizer out to use between glove changes. NA-A	F 441	**(This page intentionally left blank)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER	109 COURT AVENUE SOUTH SANDSTONE, MN 55072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 verified she was going out of the room and did not was or sanitize her hands when before exiting the room. On 9/11/14, at 9:45 a.m. the director of nursing stated she would expect staff to wash or sanitize her hands when going from dirty to clean and before exiting the room.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean kitchen equipment for 2 of 2 ovens which had the potential to affect 39 out of 41 residents who's meals were prepared in the facility's kitchen. Findings Include: On 9/9/14, at 2:16 p.m. during the tour of the kitchen with the dietitian the following was observed: There were two stacked silver colored ovens that were located between the convection oven on the left and the stove on the right. The ledge under the top oven was entirely covered with a brown substance. The inside of the oven door had brown/black substance on it along with the fan in the back of the oven. In addition, the ledge under the bottom oven had brown/black colored drippings on it. The inside of the oven	F 465	**F465** **Element #1** ~~2 of 2 ovens that were~~ found to be dirty upon initial inspection were cleaned. **Element #2** There are a total of 4 ovens in the kitchen that could be affected by the deficient practice. **Element #3** The deficient practice was determined to be caused by the changing of job duties on interim basis until a Dietary Manager was recruited. A manager has been hired and the nutrition aide has resumed cleaning of ovens on a weekly basis. She will clean one oven each week on an ongoing basis. **Element #4** The Nutrition Services Manager or designee will complete audits on the cleanliness of all ovens in the kitchen. Audits will be monthly x 3 months, quarterly x 3 months and then	

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	245454	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER	109 COURT AVENUE SOUTH SANDSTONE, MN 55072

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F 465	Continued From page 15 door had a rough speckled brown color substance covering the majority of the door. The bottom surface of the oven starting in the front middle section of the oven and extending to to the right side of the oven had a brown/black colored substance on it. The dietitian and the cook (Cook-A) verified the ovens were dirty and had not been cleaned. The cleaning of the oven is on a rotating 3 week cleaning schedule. The dietitian said there was a cleaning sheet to be signed off.	F 465	as needed based upon audit findings. Negative findings will be reported at the quarterly QAPI meetings. **Element #5** The facility was incompliance with F465 on 9/24/2014.	
	Review of the routine cleaning sheet with a revision date of 6/19/13 for July and August 2014 had listed on it to clean the ovens on a monthly basis on Wednesday. The weekly dates from 7/23 to 7/30, 8/20 to 8/27, 9/3 and 9/10 had a x in the box under those dates for cleaning the oven. The September 2014 cooks daily cleaning sheet had documentation the oven doors were cleaned. On 9/11/14 at approximately 2:30 pm the dietitian said she checked with the person responsible for cleaning the ovens and it had not been done. The Cleaning schedule policy with a review/revision date of 5/14 indicated the facility must store, prepare, distribute and serve food under sanitary conditions. It further indicated, it is the responsibility of the nutritional service manager to enforce the cleaning schedules and monitor completion of the assigned cleaning task.			

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	245454	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/10/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - SANDSTONE MEDICAL C	**109 COURT AVENUE SOUTH SANDSTONE, MN 55072**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Essentia Health Sandstone Nursing Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Essentia Health Sandstone Nursing Home, is a 1-story building with a partial basement. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1988 an addition was constructed to the building that was determined to be of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is fully fire sprinklered throughout. The facility 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. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 45 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6924

September 22, 2014

Ms. Jamie Paro, Administrator
Essentia Health - Sandstone Medical Center
109 Court Avenue South
Sandstone, MN 55072

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5454024

Dear Ms. Paro:

The above facility was surveyed on September 8, 2014 through September 11, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Patricia Halverson, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Patricia.halverson@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Patricia Halverson at the number of email listed above.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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