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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7VC7

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) **SANDSTONE HEALTH CARE 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) **05/17/2017**

6. DATE OF SURVEY **09/22/2021** (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 **50** (L18)

13.Total Certified Beds **50** (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
	50			
(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 :
Susan Frericks, Unit Supervisor 10/19/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/19/2021 (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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/04/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 19, 2021

CMS Certification Number (CCN): 245454

Administrator
Sandstone Health Care Center
109 Court Avenue South
Sandstone, MN 55072

Dear Administrator:

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 September 16, 2021 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 19, 2021

Administrator
Sandstone Health Care Center
109 Court Avenue South
Sandstone, MN 55072

RE: CCN: 245454
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 25, 2021, we notified you a remedy was imposed. On September 22, 2021 the Minnesota Department(s) 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 16, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 9, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 25, 2021, 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 9, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 16, 2021, 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.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7VC7

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(L3) **SANDSTONE HEALTH CARE CENTER**
(L4) **109 COURT AVENUE SOUTH**
(L5) **SANDSTONE, MN** (L6) **55072**

4. TYPE OF ACTION: **2** (L8)

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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) **05/17/2017**

6. DATE OF SURVEY **08/05/2021** (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

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From (a) :
To (b) :

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Sativa Bushey, HFE - NE II 09/23/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/01/2021 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 25, 2021

Administrator
Sandstone Health Care Center
109 Court Avenue South
Sandstone, MN 55072

RE: CCN: 245454
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 5, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 9, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 9, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 9, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 9, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Sandstone Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 9, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 5, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HEALTH CARE 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
E 000	Initial Comments On 8/2/21, through 8/5/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/2/21, through 8/5/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5454013C (MN523959), H5454017C (MN73569), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5454014C (MN69781), H5454015C (MN71827), and H5454016C (MN73034), H5454018C (MN75203). 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	F 000		

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

Electronically Signed | 09/01/2021

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 _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HEALTH CARE 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	Continued From page 1 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 substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment for safety with self-administration of medications was completed prior to self-administration of a nebulizer treatment for 1 of 1 residents (R187) observed during a nebulizer treatment. Findings include: R187's Admission Record printed 8/5/21, indicated R187 had been admitted with diagnoses that included pneumonia, anxiety disorder, encephalopathy (disease of the brain), chronic obstructive pulmonary disease (COPD) and emphysema. R187's Order Summary Report as of 8/3/21, indicated R187's physician orders included: -Budesonide Suspension (used to control and prevent wheezing and shortness of breath) 0.5 milligrams (mg)/2 milliliters (ml), 2 ml inhale orally every morning and at bedtime for COPD.	F 554	F554 Self-Admin of Meds-Clinically Appropriate R187 was left alone in room to self-administer nebulizer treatment following set-up by staff. R187 did not have an appropriate self-administration assessment complete by a nurse prior to administration. All residents with nebulizer orders have the potential to be affected by a deficient practice in this area. All medication administration staff training on finding to be complete by DON. Self-administration policy reviewed and revised as needed. DON or designee will complete random audits of nebulizer orders to ensure appropriate assessment complete prior to administration 2x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Audit result will be brought to QAPI Committee for review and further recommendations. Completion date:	9/16/21

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 _____	C 08/05/2021

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

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F 554	Continued From page 2 -Ipratropium-Albuterol Solution (treatment of bronchospasm associated with COPD) 0.5-2.5 (3) mg/3 ml, 3 ml inhale orally every four hours while awake for COPD. R187's physician orders lacked an order for self-administration of medications. R187's Medication Administration Record (MAR) for August 2021, indicated R187 received Budesonide Suspension 0.5 mg/2 ml 2 ml inhaled orally during the morning of 8/4/21. R187's MAR lacked directives for self-administration of medications. R187's medical record lacked an assessment for safety with self-administration of medications or an assessment of her cognitive status. On 8/4/21, at 7:53 a.m. R187 was observed sitting in her room with a nebulizer treatment. Licensed practical nurse (LPN)-A was observed to leave R187's room after setting her up with a nebulizer treatment. LPN-A stated she set R187 up with Budesonide, 2 ml. LPN-A verified R187 did not have an order for self-administration of her nebulizers. LPN-A stated residents should have an order based on an assessment of their cognitive status. LPN-A stated R187 was alert and oriented and kept track of her medications. LPN-A stated the RN usually assessed for safe self-administration of medications. On 8/4/21, at 3:00 p.m. the director of nursing (DON) stated she would expect residents to be supervised during administration of medications, including nebulizers if they did not have a physician's order for self-administration of	F 554	9/16/21	

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F 554	Continued From page 3 medications. The DON verified R187 did not have an order for self-administration of medications. A facility policy and procedure for Self-administration of medications was requested and not received.	F 554		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a new non-pressure-related skin impairment was assessed and the physician was notified to initiate appropriate interventions to promote healing for 1 of 3 residents (R22) reviewed for pressure ulcers. Findings include: R22's Admission Record printed 8/5/21, indicated R22's diagnoses included weakness, malignant neoplasm of the brain, and peripheral vascular disease. R22's comprehensive annual Minimum Data Set dated 6/8/21, indicated R22 had a moderate cognitive impairment, had no rejection-of-care	F 684	F684 Quality of Care R22 had presence of MASD which was not appropriately assessed by nursing staff and provider updated as appropriate. All resident who are at risk for skin breakdown have the potential to affected by a deficient practice in this area. Staff training on findings to be complete by DON. Skin policy reviewed and revised as needed. All Braden risk assessments reviewed for those at risk for skin breakdown. New skin assessments by RN to be complete on those found to be at risk and care plans updated with appropriate interventions and providers updated as indicated. DON or designee will complete random audits of skin	9/16/21

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F 684	Continued From page 4 behaviors during the assessment period, required extensive assist of staff for bed mobility and toilet use, and required total assist of staff for transfers. R22's MDS further indicated R22 was always incontinent of bladder and frequently incontinent of bowel, was at risk for pressure ulcers, had one pressure ulcer and had an area of moisture associated skin damage (MASD). R22's undated Care Area Assessment (CAA) for MDS assessment of 6/8/21, identified R22 as having a MASD, but lacked assessment of R22's MASD. R22's care plan revised 6/18/21, indicated R22 was at risk for skin breakdown with a risk factors that included incontinence. R22's care plan further indicated R22 currently had a healing pressure injury to the right heel with a goal of no new redness or open areas through the next review date. R22's interventions directed staff to keep R22's skin clean and dry, lotion dry skin, observe skin daily with cares and weekly with R22's bath, use a barrier cream to protect skin upon rising, at bedtime and after each incontinent episode. R22's care plan further directed staff to provide wound care as ordered by the primary care physician, and update R22's hospice provider with any new skin issues. In addition, R22's care plan indicated R22 was incontinent of bladder and frequently incontinent of bowel and frequently refused to allow staff to check or change her brief. R22's care plan lacked identification of R22's open areas related to MASD on her buttocks. R22's Braden Scale for Predicting Pressure Ulcer Risk dated 6/2/21, indicated R22 was at high risk for pressure ulcer development, with a risk factor	F 684	assessments, provider updates, and appropriate treatment 2x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Audit result will be brought to QAPI Committee for review and further recommendations. Completion date: 9/16/21	

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of being very moist.

R22's Benefits vs. Risk (Refusal to Treat) form dated 11/25/19, indicated R22 was non-compliant with toileting and check or change, and was informed of the risks related to noncompliance including the increased risk for skin impairments.

R22's daily Monitoring-Skin Observation documented in the nursing assistants Tasks indicated a "red area" had been checked on 7/721, 7/8/21, twice on 7/9/21, 7/18/21, 7/21/21, 7/23/21, 7/27/21, 7/28/21, 7/31/21, and twice on 8/4/21. The documentation did not identify where the red area was. An "open area" had been checked on 7/9/21, 7/30/21, and 8/3/21, but did not identify where the open area was. Most other dates of documentation indicated there were "none of the above observed."

R22's progress notes dated 7/1/21, through 8/4/21, lacked identification of skin impairment on R22's buttocks. R22's progress notes dated 7/26/21, indicated during a hospice visit while sitting up in her Broda chair (high-back, tilting wheelchair to aid in positioning and decrease risk of skin breakdown), R22's heel pressure ulcer was healed and all skin remained intact. R22 had remained seated in her Broda chair during the visit.

R22's physician progress notes dated 7/14/21, lacked identification of a skin impairment on her buttocks.

On 8/2/21, at 2:44 p.m. during an interview, R22 was yelling out in pain, and stated her pain was on her buttocks.

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On 8/3/21, at 2:09 p.m. R22 was lying in bed and nursing assistant (NA)-C asked R22 if she wanted to get up, and R22 declined to get up. NA-A then approached R22 and asked if she wanted to get up, but again, R22 declined. NA-A respectfully convinced R22 to allow them to straighten her up. NA-C and NA-B closed R22's door.

On 8/3/21, at 2:16 p.m. NA-B and NA-C exited R22's room with a bag of garbage. NA-B stated R22 refused repositioning about 50% of the time and had a small open area on her bottom that had been there for "awhile". NA-B stated R22's open area was not getting worse, but stated R22 often refused repositioning. NA-B stated the nurses would look at R22's skin and document on it.

On 8/3/21, at 2:23 p.m. NA-C stated she had reported R22's skin issue, but would report it again. NA-C stated she documented it every day in the task charting. NA-C stated in their documentation, it asked if the area was new and she put "no." NA-C stated R22's skin impairment on her buttocks was an ongoing issue for R22.

On 8/4/21, at 8:48 a.m. registered nurse (RN)-A entered R22's room to look at the area on R22's ankle and heel. When asked if she was going to look at R22's bottom, she said she would, but was not aware of any open areas on R22's bottom, so had not intended to look at that area. R22's heel had not opened. R22 was turned to her left and RN-A identified two open areas on R22's right buttock just on the edge of the coccyx, as moisture related due to the white areas of maceration around the edges. RN-A stated R22 had a history of refusing to be changed and

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repositioned. RN-A measured the larger, lower open area at 1.5 centimeters (cm) x 2.0 cm with 0.5 cm of maceration to the anterior aspect. RN-A measured the smaller, upper open area at 0.5 cm x 0.5 cm with non-blanchable redness surrounding. RN-A stated the edges were irregular. Barrier cream was applied before putting on a clean incontinent brief.

On 8/4/21, at 9:47 a.m. NA-D stated R22 has had an open area on her bottom for approximately a month and a half, and they put barrier cream on it. NA-D stated if the area is not new, they check the "none" box, and only check the open-area box if it is new to them. NA-D stated she communicates daily with the nurse, but was not sure if the nurse checked R22's skin routinely.

On 8/4/21, at 9:56 a.m. the hospice RN stated she had been made aware of an area on R22's bottom last week, but said she did not manage R22's skin concerns, though she was aware that staff were putting barrier cream on it.

On 8/4/21, at 9:57 a.m. LPN-A stated nursing assistants report skin impairments to the nurse and a "stop and watch" sheet is filled out, which is reviewed by the and turned into the RN manager. If it is reported, the nurse goes to look at the skin impairment, measures it, charts the characteristics and if a staged ulcer, the nurse will get the RN manager to look at it right away so treatment could be initiated. LPN-A stated the family and physician would be notified of any skin impairment. LPN-A stated the nurses don't look at skin routinely on the bath day unless they are notified of an area of concern.

On 8/4/21, at 11:21 a.m. RN-A stated the bath

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aides report any skin concerns to the floor nurse, the nurse does a risk management. If the bath aides report anything then they look the resident's skin, but they do not routinely look at the resident's skin. RN-A stated the nursing assistants recorded if there were any new skin injuries, but if they were continuing areas, there was a place they can indicate if they are new or not. RN-A stated they do not necessarily look at the NA charting, as they report skin concerns to the nurse. RN-A reviewed R22's skin task documentation and verified there were dates documented as an open area, with the first being on 7/9/21, though the documentation history only went back 30 days. RN-A further verified the documentation was identified as not being a new area and the NA documentation had not been utilized. RN-A stated she would follow up on skin concerns when they were reported by the nurses, and further stated there appeared to be a breakdown in the NA communication with the nurse. RN-A stated the family and provider had not been notified of R22's new open areas.

On 8/4/21, at 3:00 p.m. the director of nursing (DON) stated the nursing assistant documented skin checks, notified the nurses, who then assessed the skin concerns and notified the RN manager. The DON stated RN-A was the wound nurse, measured and documented skin concerns and coordinated with the medical provider. The DON stated her expectation was for nursing to report and follow up on worsening skin conditions. The DON stated R22's skin concerns had not been on the 24-hour report, so was not triggered. DON stated when a skin concern was identified, it was monitored and followed up on.

The facility policy and procedure for Pressure

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F 684	Continued From page 9 Ulcer/Skin Risk Assessment revised 7/5/21, indicated pressure ulcers could be made worse by several factors, including moisture. The facility policy and procedure directed nursing staff to perform routine skin inspections with daily care and nurses were to be notified to inspect the skin if skin changes were identified. Nurses would then implement at least weekly assessments. The facility policy and procedure further directed prompt identification and implementation of interventions to attempt to prevent pressure ulcers. The facility policy and procedure for Skin Tears-Care of Abrasions, Impairments, and Minor Breaks revised 9/13, directed nursing to complete an in-house investigation of causation, document physician and family notification, resident education, and document interventions implemented. The facility policy and procedure for Change in a Resident's Condition or Status revised 12/16, directed nursing to notify the resident's physician or healthcare provider after making a detailed observation and gathering of relevant and pertinent information. The nurse was to record a resident's change in medical status in the medical record.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		9/16/21

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F 686	Continued From page 10 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning for 1 of 3 residents (R6) reviewed for pressure ulcers. Findings include: R6's Face Sheet dated 8/6/21, indicated R6's diagnoses included Guillain-Barre Syndrome (a condition in which the immune system attacks the nerves), extended spectrum beta lactamase (ESBL) resistance bacteria (bacteria resistant to antibiotics), quadriplegia (paralysis of all four limbs), chronic pain syndrome, depression, and neuromuscular dysfunctional bladder. R6's quarterly Minimum Data Set (MDS) dated, 65/28/21, indicated R6 was cognitively intact, and required extensive assistance with bed mobility, transfers, dressing, toileting, eating, and personal hygiene. R6's MDS further indicated R6 had and indwelling catheter and was continent of bowel. R6's care plan revised 8/6/21, indicated R6 was at risk for the development of pressure ulcers related to impaired mobility secondary to quadriplegia, and R6 had a chronic history of skin breakdown. R6's care plan directed staff to follow facility policies and procedures for the	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer R6 did not have timely repositing performed per care plan as part of skin breakdown prevention. All resident who are at risk for skin breakdown have the potential to affected by a deficient practice in this area. Staff training on findings to be complete by DON. Skin policy reviewed and revised as needed. All Braden risk assessments reviewed for those at risk for skin breakdown. New skin assessments by RN to be complete on those found to be at risk and care plans updated with appropriate interventions and providers updated as indicated. DON or designee will complete random audits of skin assessments, provider updates, and appropriate treatment 2x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Audit result will be brought to QAPI Committee for review and further recommendations. Completion date: 9/16/21	

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prevention/treatment of skin breakdown. R6's care plan further indicated R6 preferred to remain in her chair and declined offloading and shifting. R6's care plan indicated R6 had a self- care deficit and required assistance with toileting, bathing, personal cares, dressing, eating, bed mobility and transfers. R6's care plan further indicated R6 was at risk for further skin breakdown, and indicated R6 wished to be independent with repositioning during the day and would notify when assistance was needed. R6's care plan indicated R6 would accept assistance with repositioning once in the morning and once at bedtime.

R6's Order Summary Report dated 6/16/21, directed staff to document any refusal of care, including wound care, and repositioning every shift. R6's Order Summary Report directed to cleanse R6's old pressure injury to right hip with Witch Hazel and a cotton ball every shift for skin breakdown.

R6's Braden Scale for Predicting Pressure Ulcer Risk dated 5/28/21, indicated R6's sensory perception related to the ability to respond meaningful to pressure-related discomfort was very limited and responded only to painful stimulus. R6's skin was very moist, R6 was chairfast, had very limited ability to change and control body position, and required moderate to maximum assist in moving and lifting R6 without sliding against sheets were impossible. R6's Braden Score was 12 indicating a high risk for the development of pressure ulcers.

R6's Benefits VS. Risk dated 6/15/21, indicated area of concern was R6 not repositioning when out on leave of absence (LOA). The benefits

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listed were go and do as you wish, and the risks included increase risk for skin breakdown and impairments. The Benefits vs Risks form did not include the benefits or risks of R6's concern of refusing and not allowing staff to assist with repositioning while in R6 was in the facility.

On 8/04/21, from 7:48 a.m. through 10:49 a.m. R6 was continuously observed. R6 was not offered repositioning or toileting during that time of (three hours and one minute).

On 8/04/21, at 10:34 a.m. NA-E stated R6 preferred to sleep in her wheelchair, required two assists for transfers, and would notify staff when she needed to use the commode or repositioned. NA-E further stated R6 repositioned herself by tilting herself back in the wheelchair, and declined staff to assist with repositioning. NA- E stated R6 was repositioned at 7:45 a.m. when NA-E assisted R6's with cares. NA-E stated R6's care plan directed to offer R6 repositioning every two hours but staff waited for R6 to request for repositioning since R6 often refused. NA-E verified R6 had not been offered or repositioned since 7:45 a.m.

On 8/04/21, at 10:40 a.m. registered nurse (RN)-A stated R6 required assistance of two for transfers and repositioning. RN-A sated R6 preferred to sleep in her customized powered wheelchair and was able to independently reposition by tilting her wheelchair. RN-A stated R6 tilting her wheelchair was not technically considered offloading but that was what R6 allowed for repositioning. RN-A stated R6's care plan directed staff to offer positioning every two hours, and did not reflect what R6 would allow staff to do. RN-A further stated staff should be

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offering repositioning every two hours even though R6 had a history of refusing.

On 8/04/21, at 10:49 a.m. RN-A entered R6's room asked R6 if staff could reposition her and check her skin on her buttock and backside since it had been over three hours since R6 was last repositioned. R6 declined to get out of her chair and have a skin check. R6 stated she got up twice a day, once in the morning an once before bed.

On 8/04/21, at 10:52 a.m. R6 stated staff no longer offered to reposition R6 every two hours because staff knew R6 would refuse. R6 stated she was able to put her call light on if she needed to have a bowel movement, or wanted to be positioned. R6 stated she has a specialized/custom wheelchair that was specifically made to give relief from pressured areas.

On 8/05/21, at 11:31 a.m. the director of nursing (DON) stated she would expect staff to follow the residents plan of care, and further stated the residents plan of care was based on assessment and the needs of the resident. The DON stated R6 had a history of refusing to be repositioned, R6 was educated, and signed a Benefits vs. Risk. The DON stated R6 had a customized wheelchair which allowed R6 to modify her position independently by tilting the wheelchair. The DON further stated she would expect staff to continue and offer R6's turning and repositioning opportunities even though R6 had a history of refusing. The DON verified R6's care plan did not reflect interventions of R6 wishes to be independent with repositioning during the day, and only willing to accept assistance with

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F 686	Continued From page 14 repositioning from staff in the morning and at bedtime. The facility policy Repositioning revised 5/2013, directed for repositioning the resident in the chair, to encourage the chair bound resident, who was able to move, change positions or shift weight at least every 15 minutes. The policy directed to check the care plan, assignment sheet or the communication system to determine resident-specific positioning needs and directed to assist the resident in changing his or her position in the chair. The policy directed staff to notify the supervisor if the resident refuses the procedure. The policy further directed if the resident refuses care, an evaluation of the basis for the refusal, and the identification and evaluation of potential alternatives are indicated. The facility policy Requesting, Refusing and/or Discontinuing Care or Treatment revised 12/2016, indicated if a resident refused care or treatment, the Unit Manager, Charge Nurse, or Director of Nursing will meet with the resident, determine why the resident is refusing, address concern, and discuss other options and potential outcomes or consequences. The facility policy Care Plans, Comprehensive Person-Centered dated 12/2016, indicated assessments of residents were ongoing and care plans were revised as information about the residents and the residents condition changes.	F 686		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		9/16/21

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	245454	A. BUILDING _____ B. WING _____	C 08/05/2021

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F 756	Continued From page 15 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure continued use of a	F 756	F756 Drug Regimen Review, Report Irregular, Act On CFRs	

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F 756	Continued From page 16 proton-pump inhibitor ([PPI] a medication used to treat heartburn) was evaluated for continued use for 1 of 5 (R12) residents reviewed for unnecessary medications. Findings include: R12's Admission Record printed on 8/5/21, indicated diagnoses that included gastro-esophageal reflux disease without esophagitis (a digestive disease in which stomach acid or bile irritates the food pipe lining). R12's quarterly Minimum Data Set (MDS) dated 6/24/21, indicated R12 was severely cognitively impaired, had no behaviors, required supervision with eating, and required extensive assistance with activities of daily living. R12's Order Summary Report printed on 8/5/21, indicated R12 had an active order for Omeprazole (a proton-pump inhibitor) 20 milligrams (mg) to be given daily before breakfast. The order had a start date of 10/24/19, with no end date. R12's monthly medication pharmacist reviews for the past year 8/2020, through 7/2021, did not address her Omeprazole use. R12's 60 day physician progress notes from 8/28/20, through 7/14/21, did not address her Omeprazole use. On 8/5/21, at 9:01 a.m. the consulting pharmacist (CP)-B was interviewed. CP-B verified R12's Omeprazole had been started in 2019. CP-B verified the Omeprazole use should have been reviewed by R12's provider after four weeks of	F 756	R12 has dx of GERD for which resident receives a PPI. Facility failed to ensure timely review of continued use of this medication. Staff training on findings to be complete by DON. Medication review policy for unnecessary medications to be reviewed and updated as indicated. DON or designee will complete random audits of resident medication lists 2x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Facility looking into options for new pharmacy consulting team. Audit result will be brought to QAPI Committee for review and further recommendations. Completion date: 9/16/21	

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F 756	Continued From page 17 use. On 8/5/21, at 12:15 p.m. the director of nursing (DON) verified she would expect the pharmacist to make recommendations for medication use based on national standards of care. The prescribing information revised 9/2012, indicated Omeprazole's frequency for use was once daily for four weeks. In addition some patients may require an additional four weeks of use. Warnings and precautions of long term use were included with the prescribing information provided by the facility.	F 756		
F 880 SS=E	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: §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	F 880		9/16/21

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F 880	Continued From page 18 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 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.	F 880		

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F 880	Continued From page 19 §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 ensure appropriate personal protective equipment (PPE) was used when caring for residents on contact precautions for 1 of 5 residents (R6) reviewed for isolation precautions. The facility also failed to ensure a resident's oxygen tubing was kept off the floor for 1 of 2 residents (R188) reviewed for oxygen therapy. In addition, the facility failed to ensure proper hand hygiene practices were maintained during the meal tray pass which had the potential to affect all residents who were served meals in the facility. Findings include: R6's Face Sheet dated 8/6/21, indicated R6's diagnoses included Guillain-Barre Syndrome (a condition in which the immune system attacks the nerves), extended spectrum beta lactamase (ESBL) resistance bacteria (bacteria resistant to antibiotics), quadriplegia, chronic pain syndrome, and neuromuscular dysfunctional bladder. R6's quarterly Minimum Data Set (MDS) dated, 5/28/21, indicated R6 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. R6's MDS further indicated R6 had an indwelling catheter and was continent of bowel. R6's care plan revised 6/3/21, indicated R6 had ESBL in her urine, and required assistance with	F 880	PPE for resident on precautions: Facility failed to ensure adequate use of PPE for R6 who was on contact precautions. Staff training on findings to be complete by DON. PPE policy reviewed and revised as needed. DON or designee will complete random audits of PPE use and appropriate care planning for those on precautions 2x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Facility looking into options for new pharmacy consulting team. Audit result will be brought to QAPI Committee for review and further recommendations. Nasal Cannula Oxygen: R188 oxygen tubing noted to be touching to floor. Oxygen tubing was not changed despite continued use. Oxygen administration/tubing policy reviewed and updated as needed. Staff training on findings to be complete by DON. DON or designee will complete random audits of oxygen tubing placement/changes 2x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Audit result will be brought to QAPI Committee for review and further recommendations. Hand hygiene during meal tray pass: During evening meal pass in the dining room, DA-A noted to not was hands or change gloves between residents. DA-A	

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F 880	Continued From page 20 activities of daily living (ADL's). R6's care plan lacked identification R6 was on contact precautions, and further lack the direction to wear an isolation gown and gloves when providing personal cares for R6. On 8/3/21, at 7:48 a.m. R6's room was observed to have "STOP" sign on the outside of the door indicating "Contact Precautions" and instructed to clean hands before entering and when leaving the room. The Contact Precaution sign further directed gloves to be worn before room entry and discarded before exiting the room, and gowns were to be put on before room entry and discarded before room exit. On 8/3/21, at 9:32 a.m. nursing assistant (NA)-E entered R6's room who was on Contact Precautions, without wearing an isolation gown or eye protection and assisted R6 in getting washed and dressed for the day. NA-E put on gloves, wet a washcloth and began to wash R6's face. Licensed practical nurse (LPN)-B entered R6's room and instructed NA-E to put on an isolation gown while assisting R6 with cares. On 8/3/21, at 9:34 a.m. LPN-B stated NA-E should have worn a gown, gloves, mask, and eye protection while working with R6 who was on contact precautions for ESBL in her urine. On 8/03/21, at 1:03 p.m. NA-E stated R6 was on contact precautions, and required a gown, gloves, eye protection, and a mask to be worn when assisting R6 with personal cares, or managing R6's urinary catheter bag. NA-E verified she was not wearing an isolation gown or eye protection at the time she assisted R6 with cares that morning.	F 880	also did not wash hands or change gloves after picking up trash from the floor, touching door handle, and touching face. Hand hygiene policy reviewed and revised as needed. Staff training on finding to be complete with dietary staff by DON or Dietary manager. DON or designee will complete random audits hand hygiene in the dining room 2x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Audit result will be brought to QAPI Committee for review and further recommendations.	

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F 880	Continued From page 21	F 880		

On 8/05/21, at 11:31 a.m. the director of nursing (DON) stated she would expect staff to follow the signs posted outside of the resident's room for directions on what personal protective equipment (PPE) was required before entry into a room on precautions. The DON verified R6 was on contact precautions and stated she expected staff to wear an isolation gown, gloves, mask and eye protection upon entering R6's room. The DON further stated not using the appropriate PPE had the potential for transmission of disease and infections.

The facility policy Isolation-Categories of Transmission Based Precautions revised 1/2021, indicated in addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident care items in the resident's environment. Examples of infections requiring Contact Precautions included but not limited to: Infections with multi-drug resistant organisms. The policy further directed staff to wear a gown, and gloves upon entering the room.

NASAL CANNULA FOR OXYGEN THERAPY
R188's Transfer/Discharge Report printed on 8/4/21, indicated diagnoses that included essential hypertension (high blood pressure), legal blindness, type I diabetes, dependence on renal dialysis, and obstructive sleep apnea (intermittent airflow blockage during sleep).

R188's admission Minimum Data Set (MDS) dated 7/13/21, indicated R188 was legally blind,

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F 880	Continued From page 22	F 880		

cognitively intact, and required extensive assistance of two for activities of daily living. In addition, R188's MDS indicated she was receiving oxygen therapy and continuous positive airway pressure (CPAP [therapy in which a machine delivers positive airway pressure to support the airway during sleep]).

R188's care plan initiated 7/26/21, directed staff to use her CPAP as ordered, and to use supplemental oxygen starting at 3 liters to keep oxygen saturations above 90 percent.

On 8/3/21, at 1:50 p.m. R188's nasal cannula was observed lying on the floor; the tubing had a piece of tape with the date 7/21/21.

On 8/4/21, at 7:10 a.m. R188's nasal cannula was lying on the bed, the date on the tubing remained 7/21/21. R188 was not in her room.

During an observation and interview on 8/4/21, at 2:03 p.m., R188 was in her room and she was wearing the nasal cannula dated 7/21/21, that had been on the floor that morning. Licensed practical nurse (LPN)-A verified the nasal cannula was dated 7/1/21. LPN-A verified she would expect any staff who found a nasal cannula on the floor would throw it away and replace the tubing.

During an interview on 8/5/21, at 12:35 p.m. the director of nursing (DON) verified she would expect staff to replace nasal cannula found on the floor with new tubing.

The facility policy titled Oxygen Administration dated 10/2010, did not address when a nasal cannula should be replaced.

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F 880	Continued From page 23 HAND HYGIENE DURING MEAL TRAY PASS On 8/2/21, at 4:51 p.m. dietary aid (DA)-A was observed in the dining room taking orders from each resident for drinks. DA-A did not wash her hands or changing gloves between serving residents. On 8/2/21, at 5:08 p.m. DA-A picked up trash from the dining room floor and did not change gloves or perform hand hygiene before continuing to serve residents. On 8/2/21, at 5:22 p.m. DA-A touched the kitchen door handle and her face, DA-A did not change gloves or perform hand hygiene before continuing to serve residents. On 8/2/21, at approximately 6:00 p.m. DA-A was interviewed. DA-A verified that she had assisted residents with their drinks and had not performed hand hygiene before or after delivering drinks during the dinner meal. On 8/2/21, at 6:10 p.m. the nutritional director (ND)-E verified as she passed trays she did not perform hand hygiene before or after delivering meal trays during the dinner meal. ND-E verified she should have performed hand hygiene after delivering a tray and exiting a resident room and prior to picking up a new meal tray. On 8/4/21, at 3:01 p.m. the nutritional director (ND)-E was interviewed. ND-E verified that she had passed trays and did not perform hand hygiene before or after delivering meal trays during the dinner meal. She further stated that DA-A had not performed hand hygiene before or	F 880		

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F 880	Continued From page 24 after delivering drinks to residents during the dinner meal. The facility policy titled Handwashing/Hand Hygiene dated 8/2015, directed staff to perform hand hygiene before and after direct contact with residents and before and after assisting a resident with meals.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 25, 2021

Administrator
Sandstone Health Care Center
109 Court Avenue South
Sandstone, MN 55072

Re: State Nursing Home Licensing Orders
Event ID: 7VC711

Dear Administrator:

The above facility was surveyed on August 2, 2021 through August 5, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 8/2/21, through 8/5/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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	00452	A. BUILDING: _____ B. WING _____	08/05/2021

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5454013C (MN523959), H5454017C (MN73569), however with no licensing issued. The following complaints were found to be UNSUBSTANTIATED: H5454014C (MN69781), H5454015C (MN71827), and H5454016C (MN73034), H5454018C (MN75203), with no licensing issued. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in	2 302		9/16/21

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2 302	Continued From page 3 written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided in written or electronic form, a description of facility staff training for the care of residents with dementia/Alzheimer's, categories of staff trained, frequency of training and topics covered in the training. This had the potential to affect all 45 residents in the facility, and resident representatives/families. Findings include: On 8/5/21, at 10:37 a.m. the director of nursing (DON) was interviewed. The DON verified there was no information regarding training on dementia/Alzheimer's provided to residents or resident representatives/families. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents or resident representatives/family are notified of training on dementia/Alzheimer's. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing	2 302	corrected	

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2 302	Continued From page 4 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a new non-pressure-related skin impairment was assessed and the physician was notified to initiate appropriate interventions to promote healing for 1 of 3 residents (R22) reviewed for pressure ulcers. Findings include: R22's Admission Record printed 8/5/21, indicated R22's diagnoses included weakness, malignant neoplasm of the brain, and peripheral vascular disease.	2 830	corrected	9/16/21

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2 830	Continued From page 5 R22's comprehensive annual Minimum Data Set dated 6/8/21, indicated R22 had a moderate cognitive impairment, had no rejection-of-care behaviors during the assessment period, required extensive assist of staff for bed mobility and toilet use, and required total assist of staff for transfers. R22's MDS further indicated R22 was always incontinent of bladder and frequently incontinent of bowel, was at risk for pressure ulcers, had one pressure ulcer and had an area of moisture associated skin damage (MASD). R22's undated Care Area Assessment (CAA) for MDS assessment of 6/8/21, identified R22 as having a MASD, but lacked assessment of R22's MASD. R22's care plan revised 6/18/21, indicated R22 was at risk for skin breakdown with a risk factors that included incontinence. R22's care plan further indicated R22 currently had a healing pressure injury to the right heel with a goal of no new redness or open areas through the next review date. R22's interventions directed staff to keep R22's skin clean and dry, lotion dry skin, observe skin daily with cares and weekly with R22's bath, use a barrier cream to protect skin upon rising, at bedtime and after each incontinent episode. R22's care plan further directed staff to provide wound care as ordered by the primary care physician, and update R22's hospice provider with any new skin issues. In addition, R22's care plan indicated R22 was incontinent of bladder and frequently incontinent of bowel and frequently refused to allow staff to check or change her brief. R22's care plan lacked identification of R22's open areas related to MASD on her buttocks. R22's Braden Scale for Predicting Pressure Ulcer	2 830		

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2 830	Continued From page 6 Risk dated 6/2/21, indicated R22 was at high risk for pressure ulcer development, with a risk factor of being very moist. R22's Benefits vs. Risk (Refusal to Treat) form dated 11/25/19, indicated R22 was non-compliant with toileting and check or change, and was informed of the risks related to noncompliance including the increased risk for skin impairments. R22's daily Monitoring-Skin Observation documented in the nursing assistants Tasks indicated a "red area" had been checked on 7/721, 7/8/21, twice on 7/9/21, 7/18/21, 7/21/21, 7/23/21, 7/27/21, 7/28/21, 7/31/21, and twice on 8/4/21. The documentation did not identify where the red area was. An "open area" had been checked on 7/9/21, 7/30/21, and 8/3/21, but did not identify where the open area was. Most other dates of documentation indicated there were "none of the above observed." R22's progress notes dated 7/1/21, through 8/4/21, lacked identification of skin impairment on R22's buttocks. R22's progress notes dated 7/26/21, indicated during a hospice visit while sitting up in her Broda chair (high-back, tilting wheelchair to aid in positioning and decrease risk of skin breakdown), R22's heel pressure ulcer was healed and all skin remained intact. R22 had remained seated in her Broda chair during the visit. R22's physician progress notes dated 7/14/21, lacked identification of a skin impairment on her buttocks. On 8/2/21, at 2:44 p.m. during an interview, R22 was yelling out in pain, and stated her pain was on her buttocks.	2 830		

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2 830	Continued From page 7 On 8/3/21, at 2:09 p.m. R22 was lying in bed and nursing assistant (NA)-C asked R22 if she wanted to get up, and R22 declined to get up. NA-A then approached R22 and asked if she wanted to get up, but again, R22 declined. NA-A respectfully convinced R22 to allow them to straighten her up. NA-C and NA-B closed R22's door. On 8/3/21, at 2:16 p.m. NA-B and NA-C exited R22's room with a bag of garbage. NA-B stated R22 refused repositioning about 50% of the time and had a small open area on her bottom that had been there for "awhile". NA-B stated R22's open area was not getting worse, but stated R22 often refused repositioning. NA-B stated the nurses would look at R22's skin and document on it. On 8/3/21, at 2:23 p.m. NA-C stated she had reported R22's skin issue, but would report it again. NA-C stated she documented it every day in the task charting. NA-C stated in their documentation, it asked if the area was new and she put "no." NA-C stated R22's skin impairment on her buttocks was an ongoing issue for R22. On 8/4/21, at 8:48 a.m. registered nurse (RN)-A entered R22's room to look at the area on R22's ankle and heel. When asked if she was going to look at R22's bottom, she said she would, but was not aware of any open areas on R22's bottom, so had not intended to look at that area. R22's heel had not opened. R22 was turned to her left and RN-A identified two open areas on R22's right buttock just on the edge of the coccyx, as moisture related due to the white areas of maceration around the edges. RN-A stated R22 had a history of refusing to be changed and	2 830		

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2 830	Continued From page 8	2 830		

repositioned. RN-A measured the larger, lower open area at 1.5 centimeters (cm) x 2.0 cm with 0.5 cm of maceration to the anterior aspect. RN-A measured the smaller, upper open area at 0.5 cm x 0.5 cm with non-blanchable redness surrounding. RN-A stated the edges were irregular. Barrier cream was applied before putting on a clean incontinent brief.

On 8/4/21, at 9:47 a.m. NA-D stated R22 has had an open area on her bottom for approximately a month and a half, and they put barrier cream on it. NA-D stated if the area is not new, they check the "none" box, and only check the open-area box if it is new to them. NA-D stated she communicates daily with the nurse, but was not sure if the nurse checked R22's skin routinely.

On 8/4/21, at 9:56 a.m. the hospice RN stated she had been made aware of an area on R22's bottom last week, but said she did not manage R22's skin concerns, though she was aware that staff were putting barrier cream on it.

On 8/4/21, at 9:57 a.m. LPN-A stated nursing assistants report skin impairments to the nurse and a "stop and watch" sheet is filled out, which is reviewed by the and turned into the RN manager. If it is reported, the nurse goes to look at the skin impairment, measures it, charts the characteristics and if a staged ulcer, the nurse will get the RN manager to look at it right away so treatment could be initiated. LPN-A stated the family and physician would be notified of any skin impairment. LPN-A stated the nurses don't look at skin routinely on the bath day unless they are notified of an area of concern.

On 8/4/21, at 11:21 a.m. RN-A stated the bath aides report any skin concerns to the floor nurse,

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2 830	Continued From page 9	2 830		

the nurse does a risk management. If the bath aides report anything then they look the resident's skin, but they do not routinely look at the resident's skin. RN-A stated the nursing assistants recorded if there were any new skin injuries, but if they were continuing areas, there was a place they can indicate if they are new or not. RN-A stated they do not necessarily look at the NA charting, as they report skin concerns to the nurse. RN-A reviewed R22's skin task documentation and verified there were dates documented as an open area, with the first being on 7/9/21, though the documentation history only went back 30 days. RN-A further verified the documentation was identified as not being a new area and the NA documentation had not been utilized. RN-A stated she would follow up on skin concerns when they were reported by the nurses, and further stated there appeared to be a breakdown in the NA communication with the nurse. RN-A stated the family and provider had not been notified of R22's new open areas.

On 8/4/21, at 3:00 p.m. the director of nursing (DON) stated the nursing assistant documented skin checks, notified the nurses, who then assessed the skin concerns and notified the RN manager. The DON stated RN-A was the wound nurse, measured and documented skin concerns and coordinated with the medical provider. The DON stated her expectation was for nursing to report and follow up on worsening skin conditions. The DON stated R22's skin concerns had not been on the 24-hour report, so was not triggered. DON stated when a skin concern was identified, it was monitored and followed up on.

The facility policy and procedure for Pressure Ulcer/Skin Risk Assessment revised 7/5/21, indicated pressure ulcers could be made worse

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2 830	Continued From page 10	2 830		

by several factors, including moisture. The facility policy and procedure directed nursing staff to perform routine skin inspections with daily care and nurses were to be notified to inspect the skin if skin changes were identified. Nurses would then implement at least weekly assessments. The facility policy and procedure further directed prompt identification and implementation of interventions to attempt to prevent pressure ulcers.

The facility policy and procedure for Skin Tears-Care of Abrasions, Impairments, and Minor Breaks revised 9/13, directed nursing to complete an in-house investigation of causation, document physician and family notification, resident education, and document interventions implemented.

The facility policy and procedure for Change in a Resident's Condition or Status revised 12/16, directed nursing to notify the resident's physician or healthcare provider after making a detailed observation and gathering of relevant and pertinent information. The nurse was to record a resident's change in medical status in the medical record.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure skin was assessed and providers notified of changes.
The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.
The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.

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2 830	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning for 1 of 3 residents (R6) reviewed for pressure ulcers. Findings include: R6's Face Sheet dated 8/6/21, indicated R6's diagnoses included Guillain-Barre Syndrome (a condition in which the immune system attacks the nerves), extended spectrum beta lactamase (ESBL) resistance bacteria (bacteria resistant to antibiotics), quadriplegia (paralysis of all four	2 900	corrected	9/16/21

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2 900	Continued From page 12 limbs), chronic pain syndrome, depression, and neuromuscular dysfunctional bladder. R6's quarterly Minimum Data Set (MDS) dated, 65/28/21, indicated R6 was cognitively intact, and required extensive assistance with bed mobility, transfers, dressing, toileting, eating, and personal hygiene. R6's MDS further indicated R6 had and indwelling catheter and was continent of bowel. R6's care plan revised 8/6/21, indicated R6 was at risk for the development of pressure ulcers related to impaired mobility secondary to quadriplegia, and R6 had a chronic history of skin breakdown. R6's care plan directed staff to follow facility policies and procedures for the prevention/treatment of skin breakdown. R6's care plan further indicated R6 preferred to remain in her chair and declined offloading and shifting. R6's care plan indicated R6 had a self- care deficit and required assistance with toileting, bathing, personal cares, dressing, eating, bed mobility and transfers. R6's care plan further indicated R6 was at risk for further skin breakdown, and indicated R6 wished to be independent with repositioning during the day and would notify when assistance was needed. R6's care plan indicated R6 would accept assistance with repositioning once in the morning and once at bedtime. R6's Order Summary Report dated 6/16/21, directed staff to document any refusal of care, including wound care, and repositioning every shift. R6's Order Summary Report directed to cleanse R6's old pressure injury to right hip with Witch Hazel and a cotton ball every shift for skin breakdown. R6's Braden Scale for Predicting Pressure Ulcer	2 900		

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2 900	Continued From page 13	2 900		

Risk dated 5/28/21, indicated R6's sensory perception related to the ability to respond meaningful to pressure-related discomfort was very limited and responded only to painful stimulus. R6's skin was very moist, R6 was chairfast, had very limited ability to change and control body position, and required moderate to maximum assist in moving and lifting R6 without sliding against sheets were impossible. R6's Braden Score was 12 indicating a high risk for the development of pressure ulcers.

R6's Benefits VS. Risk dated 6/15/21, indicated area of concern was R6 not repositioning when out on leave of absence (LOA). The benefits listed were go and do as you wish, and the risks included increase risk for skin breakdown and impairments. The Benefits vs Risks form did not include the benefits or risks of R6's concern of refusing and not allowing staff to assist with repositioning while in R6 was in the facility.

On 8/04/21, from 7:48 a.m. through 10:49 a.m. R6 was continuously observed. R6 was not offered repositioning or toileting during that time of (three hours and one minute).

On 8/04/21, at 10:34 a.m. NA-E stated R6 preferred to sleep in her wheelchair, required two assists for transfers, and would notify staff when she needed to use the commode or repositioned. NA-E further stated R6 repositioned herself by tilting herself back in the wheelchair, and declined staff to assist with repositioning. NA- E stated R6 was repositioned at 7:45 a.m. when NA-E assisted R6's with cares. NA-E stated R6's care plan directed to offer R6 repositioning every two hours but staff waited for R6 to request for repositioning since R6 often refused. NA-E verified R6 had not been offered or repositioned

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2 900	Continued From page 14 since 7:45 a.m. On 8/04/21, at 10:40 a.m. registered nurse (RN)-A stated R6 required assistance of two for transfers and repositioning. RN-A sated R6 preferred to sleep in her customized powered wheelchair and was able to independently reposition by tilting her wheelchair. RN-A stated R6 tilting her wheelchair was not technically considered offloading but that was what R6 allowed for repositioning. RN-A stated R6's care plan directed staff to offer positioning every two hours, and did not reflect what R6 would allow staff to do. RN-A further stated staff should be offering repositioning every two hours even though R6 had a history of refusing. On 8/04/21, at 10:49 a.m. RN-A entered R6's room asked R6 if staff could reposition her and check her skin on her buttock and backside since it had been over three hours since R6 was last repositioned. R6 declined to get out of her chair and have a skin check. R6 stated she got up twice a day, once in the morning an once before bed. On 8/04/21, at 10:52 a.m. R6 stated staff no longer offered to reposition R6 every two hours because staff knew R6 would refuse. R6 stated she was able to put her call light on if she needed to have a bowel movement, or wanted to be positioned. R6 stated she has a specialized/custom wheelchair that was specifically made to give relief from pressured areas. On 8/05/21, at 11:31 a.m. the director of nursing (DON) stated she would expect staff to follow the residents plan of care, and further stated the residents plan of care was based on assessment	2 900		

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2 900	Continued From page 15	2 900		

and the needs of the resident. The DON stated R6 had a history of refusing to be repositioned, R6 was educated, and signed a Benefits vs. Risk. The DON stated R6 had a customized wheelchair which allowed R6 to modify her position independently by tilting the wheelchair. The DON further stated she would expect staff to continue and offer R6's turning and repositioning opportunities even though R6 had a history of refusing. The DON verified R6's care plan did not reflect interventions of R6 wishes to be independent with repositioning during the day, and only willing to accept assistance with repositioning from staff in the morning and at bedtime.

The facility policy Repositioning revised 5/2013, directed for repositioning the resident in the chair, to encourage the chair bound resident, who was able to move, change positions or shift weight at least every 15 minutes. The policy directed to check the care plan, assignment sheet or the communication system to determine resident-specific positioning needs and directed to assist the resident in changing his or her position in the chair. The policy directed staff to notify the supervisor if the resident refuses the procedure. The policy further directed if the resident refuses care, an evaluation of the basis for the refusal, and the identification and evaluation of potential alternatives are indicated.

The facility policy Requesting, Refusing and/or Discontinuing Care or Treatment revised 12/2016, indicated if a resident refused care or treatment, the Unit Manager, Charge Nurse, or Director of Nursing will meet with the resident, determine why the resident is refusing, address concern, and discuss other options and potential outcomes or consequences.

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2 900	Continued From page 16 The facility policy Care Plans, Comprehensive Person-Centered dated 12/2016, indicated assessments of residents were ongoing and care plans were revised as information about the residents and the residents condition changes. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure necessary care and services are provided according to the care plan to prevent development or worsening of pressure ulcers. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was used when caring for residents on contact precautions	21375	corrected	9/16/21

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for 1 of 5 residents (R6) reviewed for isolation precautions. The facility also failed to ensure a resident's oxygen tubing was kept off the floor for 1 of 2 residents (R188) reviewed for oxygen therapy. In addition, the facility failed to ensure proper hand hygiene practices were maintained during the meal tray pass which had the potential to affect all residents who were served meals in the facility.

Findings include:

R6's Face Sheet dated 8/6/21, indicated R6's diagnoses included Guillain-Barre Syndrome (a condition in which the immune system attacks the nerves), extended spectrum beta lactamase (ESBL) resistance bacteria (bacteria resistant to antibiotics), quadriplegia, chronic pain syndrome, and neuromuscular dysfunctional bladder.

R6's quarterly Minimum Data Set (MDS) dated, 5/28/21, indicated R6 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. R6's MDS further indicated R6 had an indwelling catheter and was continent of bowel.

R6's care plan revised 6/3/21, indicated R6 had ESBL in her urine, and required assistance with activities of daily living (ADL's). R6's care plan lacked identification R6 was on contact precautions, and further lack the direction to wear an isolation gown and gloves when providing personal cares for R6.

On 8/3/21, at 7:48 a.m. R6's room was observed to have "STOP" sign on the outside of the door indicating "Contact Precautions" and instructed to clean hands before entering and when leaving the room. The Contact Precaution sign further

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21375	Continued From page 18 directed gloves to be worn before room entry and discarded before exiting the room, and gowns were to be put on before room entry and discarded before room exit. On 8/3/21, at 9:32 a.m. nursing assistant (NA)-E entered R6's room who was on Contact Precautions, without wearing an isolation gown or eye protection and assisted R6 in getting washed and dressed for the day. NA-E put on gloves, wet a washcloth and began to wash R6's face. Licensed practical nurse (LPN)-B entered R6's room and instructed NA-E to put on an isolation gown while assisting R6 with cares. On 8/3/21, at 9:34 a.m. LPN-B stated NA-E should have worn a gown, gloves, mask, and eye protection while working with R6 who was on contact precautions for ESBL in her urine. On 8/03/21, at 1:03 p.m. NA-E stated R6 was on contact precautions, and required a gown, gloves, eye protection, and a mask to be worn when assisting R6 with personal cares, or managing R6's urinary catheter bag. NA-E verified she was not wearing an isolation gown or eye protection at the time she assisted R6 with cares that morning. On 8/05/21, at 11:31 a.m. the director of nursing (DON) stated she would expect staff to follow the signs posted outside of the resident's room for directions on what personal protective equipment (PPE) was required before entry into a room on precautions. The DON verified R6 was on contact precautions and stated she expected staff to wear an isolation gown, gloves, mask and eye protection upon entering R6's room. The DON further stated not using the appropriate PPE had the potential for transmission of disease and infections.	21375		

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21375	Continued From page 19 The facility policy Isolation-Categories of Transmission Based Precautions revised 1/2021, indicated in addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident care items in the resident's environment. Examples of infections requiring Contact Precautions included but not limited to: Infections with multi-drug resistant organisms. The policy further directed staff to wear a gown, and gloves upon entering the room. NASAL CANNULA FOR OXYGEN THERAPY R188's Transfer/Discharge Report printed on 8/4/21, indicated diagnoses that included essential hypertension (high blood pressure), legal blindness, type I diabetes, dependence on renal dialysis, and obstructive sleep apnea (intermittent airflow blockage during sleep). R188's admission Minimum Data Set (MDS) dated 7/13/21, indicated R188 was legally blind, cognitively intact, and required extensive assistance of two for activities of daily living. In addition, R188's MDS indicated she was receiving oxygen therapy and continuous positive airway pressure (CPAP [therapy in which a machine delivers positive airway pressure to support the airway during sleep]). R188's care plan initiated 7/26/21, directed staff to use her CPAP as ordered, and to use supplemental oxygen starting at 3 liters to keep oxygen saturations above 90 percent. On 8/3/21, at 1:50 p.m. R188's nasal cannula	21375		

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was observed lying on the floor; the tubing had a piece of tape with the date 7/21/21.

On 8/4/21, at 7:10 a.m. R188's nasal cannula was lying on the bed, the date on the tubing remained 7/21/21. R188 was not in her room.

During an observation and interview on 8/4/21, at 2:03 p.m., R188 was in her room and she was wearing the nasal cannula dated 7/21/21, that had been on the floor that morning. Licensed practical nurse (LPN)-A verified the nasal cannula was dated 7/1/21. LPN-A verified she would expect any staff who found a nasal cannula on the floor would throw it away and replace the tubing.

During an interview on 8/5/21, at 12:35 p.m. the director of nursing (DON) verified she would expect staff to replace nasal cannula found on the floor with new tubing.

The facility policy titled Oxygen Administration dated 10/2010, did not address when a nasal cannula should be replaced.

HAND HYGIENE DURING MEAL TRAY PASS
On 8/2/21, at 4:51 p.m. dietary aid (DA)-A was observed in the dining room taking orders from each resident for drinks. DA-A did not wash her hands or changing gloves between serving residents.

On 8/2/21, at 5:08 p.m. DA-A picked up trash from the dining room floor and did not change gloves or perform hand hygiene before continuing to serve residents.

On 8/2/21, at 5:22 p.m. DA-A touched the kitchen door handle and her face, DA-A did not change

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gloves or perform hand hygiene before continuing to serve residents.

On 8/2/21, at approximately 6:00 p.m. DA-A was interviewed. DA-A verified that she had assisted residents with their drinks and had not performed hand hygiene before or after delivering drinks during the dinner meal.

On 8/2/21, at 6:10 p.m. the nutritional director (ND)-E verified as she passed trays she did not perform hand hygiene before or after delivering meal trays during the dinner meal. ND-E verified she should have performed hand hygiene after delivering a tray and exiting a resident room and prior to picking up a new meal tray.

On 8/4/21, at 3:01 p.m. the nutritional director (ND)-E was interviewed. ND-E verified that she had passed trays and did not perform hand hygiene before or after delivering meal trays during the dinner meal. She further stated that DA-A had not performed hand hygiene before or after delivering drinks to residents during the dinner meal.

The facility policy titled Handwashing/Hand Hygiene dated 8/2015, directed staff to perform hand hygiene before and after direct contact with residents and before and after assisting a resident with meals.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could review and revise policies and procedures related infection control practices including the use of PPE. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.
The Director of Nursing or designee could

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21375	Continued From page 22 develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a tuberculosis (TB) first and second test was completed for 1 of 5 residents (R188) reviewed for TB screening and testing. In addition, the facility failed to ensure a	21426	corrected	9/16/21

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21426	Continued From page 23 screening and testing was completed for 1 of 5 employees, nursing assistant (NA)-A reviewed for TB screening and testing. Findings include: R188's Transfer/Discharge Report printed 8/4/21, indicated R188 was admitted on 7/13/21and the facility screened R188 on 7/13/21, for TB. Records provided by the facility indicated R188 had a tuberculin skin test (TST) administered on 7/27/21, with results pending. R188's Medication Administration Record was reviewed for the month of July 2021, there was not a documented administration of the TST on 7/13/21. There was, however, a documented administration of the TST on 7/27/21, with no documentation of the test being read 48 hours later. On 8/5/21, registered nurse (RN)-A was interviewed. RN-A verified the TST shows up on the electronic medical record (EMAR) as a task for the nurse to administer and document the test was completed. Once the test is administered there will be another task for the nurse to read the result of the TST. RN-A verified R188's initial TST was not administered on 7/13/21, and was given first on 7/21/21, but was not read. RN-A verified R188 had not to date received a TST that was administered and read. The facility was unable to provide a Baseline TB Screening Tool for Health Care Worker NA-A. The Employee Monthly Activity Report printed on 8/4/21, indicated NA-A had worked on 7/19/21, 7/20/21, 7/28/21, and 7/29/21.	21426		

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21426	Continued From page 24 On 8/4/21, the director of nursing (DON) was interviewed. The DON was unable to locate the TB screening tool for NA-A and verified he was not currently at work. On 8/4/21, at 9:53 a.m. registered nurse (RN)-B was interviewed. RN-B stated the process for new hires was to have them complete the TST prior to starting their orientation and working on the floor. RN-B stated when they have their first TST read they schedule the second test. On 8/4/21, at 10:06 a.m. NA-A was interviewed by telephone. NA-A stated he was unable to recall if he was screened for TB. NA-A stated he had not had any TB testing done but that the facility called him on 8/4/21, and asked him to come in and get his TST. NA-A verified he had been working with residents during his orientation and without being tested for TB. On 8/4/21, at 1:06 p.m. business office manager (BO)-C was interviewed. BO-C verified the facility had asked NA-A to come in for TB testing and he would be off the schedule until the test was read. On 8/5/21, at 10:37 a.m. the DON stated all staff should be tested for TB prior to working with residents. The DON verified all residents needed to be tested for TB. The facility Screening Residents for Tuberculosis policy dated 2/10/20, indicated all residents would be screened for TB. The facility Tuberculosis Infection Control Program policy dated 11/9/18, indicated all residents and employees would be screened for latent tuberculosis infection.	21426		

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21426	Continued From page 25 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure TB screening and testing is completed for all new hires and new admissions to the facility. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.	21530		9/16/21

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21530	Continued From page 26 C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure continued use of a proton-pump inhibitor ([PPI] a medication used to treat heartburn) was evaluated for continued use for 1 of 5 (R12) residents reviewed for unnecessary medications. Findings include: R12's Admission Record printed on 8/5/21, indicated diagnoses that included gastro-esophageal reflux disease without esophagitis (a digestive disease in which stomach acid or bile irritates the food pipe lining). R12's quarterly Minimum Data Set (MDS) dated 6/24/21, indicated R12 was severely cognitively impaired, had no behaviors, required supervision with eating, and required extensive assistance	21530	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00452	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21530	Continued From page 27 with activities of daily living. R12's Order Summary Report printed on 8/5/21, indicated R12 had an active order for Omeprazole (a proton-pump inhibitor) 20 milligrams (mg) to be given daily before breakfast. The order had a start date of 10/24/19, with no end date. R12's monthly medication pharmacist reviews for the past year 8/2020, through 7/2021, did not address her Omeprazole use. R12's 60 day physician progress notes from 8/28/20, through 7/14/21, did not address her Omeprazole use. On 8/5/21, at 9:01 a.m. the consulting pharmacist (CP)-B was interviewed. CP-B verified R12's Omeprazole had been started in 2019. CP-B verified the Omeprazole use should have been reviewed by R12's provider after four weeks of use. On 8/5/21, at 12:15 p.m. the director of nursing (DON) verified she would expect the pharmacist to make recommendations for medication use based on national standards of care. The prescribing information revised 9/2012, indicated Omeprazole's frequency for use was once daily for four weeks. In addition some patients may require an additional four weeks of use. Warnings and precautions of long term use were included with the prescribing information provided by the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and	21530		

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21530	Continued From page 28 procedures to ensure medications were evaluated for continued use. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment for safety with self-administration of medications was completed prior to self-administration of a nebulizer treatment for 1 of 1 residents (R187) observed during a nebulizer treatment. Findings include: R187's Admission Record printed 8/5/21, indicated R187 had been admitted with diagnoses that included pneumonia, anxiety disorder, encephalopathy (disease of the brain), chronic obstructive pulmonary disease (COPD) and emphysema. R187's Order Summary Report as of 8/3/21, indicated R187's physician orders included:	21565	corrected	9/16/21

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21565	Continued From page 29	21565		

-Budesonide Suspension (used to control and prevent wheezing and shortness of breath) 0.5 milligrams (mg)/2 milliliters (ml), 2 ml inhale orally every morning and at bedtime for COPD.
-Ipratropium-Albuterol Solution (treatment of bronchospasm associated with COPD) 0.5-2.5 (3) mg/3 ml, 3 ml inhale orally every four hours while awake for COPD.

R187's physician orders lacked an order for self-administration of medications.

R187's Medication Administration Record (MAR) for August 2021, indicated R187 received Budesonide Suspension 0.5 mg/2 ml 2 ml inhaled orally during the morning of 8/4/21.

R187's MAR lacked directives for self-administration of medications.

R187's medical record lacked an assessment for safety with self-administration of medications or an assessment of her cognitive status.

On 8/4/21, at 7:53 a.m. R187 was observed sitting in her room with a nebulizer treatment. Licensed practical nurse (LPN)-A was observed to leave R187's room after setting her up with a nebulizer treatment. LPN-A stated she set R187 up with Budesonide, 2 ml. LPN-A verified R187 did not have an order for self-administration of her nebulizers. LPN-A stated residents should have an order based on an assessment of their cognitive status. LPN-A stated R187 was alert and oriented and kept track of her medications. LPN-A stated the RN usually assessed for safe self-administration of medications.

On 8/4/21, at 3:00 p.m. the director of nursing (DON) stated she would expect residents to be

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21565	Continued From page 30 supervised during administration of medications, including nebulizers if they did not have a physician's order for self-administration of medications. The DON verified R187 did not have an order for self-administration of medications. A facility policy and procedure for Self-administration of medications was requested and not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure self administration of medication was completed prior to use of nebulizer treaments. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		

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	245454	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/05/2021**

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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. At the time of this survey, Sandstone Health 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		09/07/2021

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

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K 000	Continued From page 1	K 000		

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.

Sandstone Health Care Center, 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. Has an attached 2 story

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K 000	Continued From page 2 Assisted Living. Remodel complete in Spring 2021. The building is fully fire sprinklered protected and also 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 50 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		9/16/21

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K 351	Continued From page 3 by: Based on observation and staff interview, the facility failed to install the sprinkler system in accordance with the NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems section 8.5.5.2.2 and 8.6.3.4.2. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1) On 08/05/2021 between 08:00 AM to 1:00 PM, it was revealed in the iPad charging station next to the printer room there are 3 Sprinkler heads within 46 inches to 60 inches of each other. 2) On 08/05/2021 between 08:00 AM to 1:00 PM, it was revealed in the boiler room there is a insulated boiler pipe touching the deflector of a sprinkler head. These deficient conditions were verified by Maintenance Director.	K 351	K351 Sprinkler System - Installation Failure to appropriately install sprinkler system. 3 sprinklers measured too close together, 1 sprinkler touching a reflector plate. Having sprinklers too close together is a safety hazard as they can interfere with each other's spray pattern during a fire situation. Two of the heads measuring too close were removed leaving the third head to cover the area appropriately. The other sprinkler that was too close to the pipe was moved away from the pipe within adequate clearance on 9/1/2021. Environmental Services director or designee will complete random audits of sprinkler placement to ensure adequate clearance from each other and objects 1x/week for 1 month, 2x/month for 1 month, and 1x/month for 4 months and quarterly thereafter. Audit result will be brought to QAPI Committee for review and further recommendations.	
K 353 SS=E	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	K 353		9/16/21

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K 353	Continued From page 4 _____ 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 the NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems section 5.2.1.1.2. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1) On 08/05/2021 between 08:00 AM to 1:00 PM, it was revealed in the kitchen there are 3 sprinkler heads covered in dust. 2) On 08/05/2021 between 08:00 AM to 1:00 PM, it was revealed in the repair room there is a sprinkler head that is painted. These deficient conditions were verified by Maintenance Director.	K 353	K353 Sprinkler System – Maintenance and Testing 3 sprinkler heads were covered in dust and 1 additional sprinkler head was noted to be painted. Having sprinkles covered in anything can affect the spray pattern during a fire situation. All sprinkler heads dusted. Sprinklers with paint replaced with new head. Environmental services director or designee will complete random audits of sprinkler heads to ensure cleanliness 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Audit result will be brought to QAPI Committee for review and further recommendations. Routine cleaning schedule to be determined based off conclusions made indicating how quickly dust accumulates on sprinkler heads.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category	K 901		9/16/21

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K 901	Continued From page 5 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and ensure the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99 (2012 Edition) Health Care Facilities Code, Chapter 4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/05/2021 between 08:00 AM to 1:00 PM, it was revealed that the required annual risk assessment per NFPA 99 was last completed on 02/18/2020. This deficient condition was verified by the Maintenance Director.	K 901	K901 fundamental – building system categories Annual risk assessment incomplete per guidelines. This deficiency has the potential to affect all residents and staff safety. New assessment complete 8/16/2021 and book updated for 2021. Risk assessment to be complete 1x/month for 3 months, quarterly until Sept 2022, and annually thereafter. Audit results will be brought to QAPI committee for review and further recommendations	
K 923 SS=D	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	K 923		9/16/21

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K 923	Continued From page 6 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or 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 the storage of oxygen tanks per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient condition could have a isolated impact on the residents within the facility.	K 923	K923 Gas Equipment – cylinder and container storage Oxygen tanks marked full and empty kept in same container. This deficiency has the potential to affect all resident's safety in an emergency. All tanks have been separated appropriately and new signs	

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K 923	Continued From page 7 Findings include: On 08/05/2021 between 08:00 AM to 1:00 PM, it was revealed that the oxygen tanks marked full were intermixed in the empty section of the oxygen room. This deficient conditions was verified by Maintenance Director.	K 923	hung on walls indicating empty and full storage areas 8/31/2021. Maintenance Director and/to DON to perform audits of Oxygen room in order to ensure correct storage of empty and full tanks 2x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter.	