DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

AND TRANSMITTAL ID: BNUW
Facility ID: 00452

		10 22 00	CETED DI		E SCILLET HOLITOR	,	
1. MEDICARE/MEDICAID PROVID (L1) 245454 2.STATE VENDOR OR MEDICAID (L2) 475213900		3. NAME AND AI (L3) ESSENTIA (L4) 109 COURT (L5) SANDSTON	HEALTH SAN FAVENUE SC	NDSTONE	(L6) 55072	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9) 01/01/2013 6. DATE OF SURVEY 10/3 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	OWNERSHIP 1/2016 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF			02 (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31	
2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATIO From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	45 (L18) 45 (L17)	Complianc1. A B. Not in Comp	equirements e Based On:	ram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	7. Medical Director	
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 45	OWN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM See Attached Remarks	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL Date:	
Theresa Ament, Uni	t Supervisor	1	11/21/2016	(L19)	Mark Meath	s, Enforcement Specialist 12/16/2016 (I	L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBIT X_ 1. Facility is Eligible to 2. Facility is not Eligible	Participate		MPLIANCE WITH	H CIVIL		nncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:	
22. ORIGINAL DATE OF PARTICIPATION 04/01/1987	23. LTC AGREED BEGINNING		4. LTC AGREEN		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure	` ′	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	sement 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		04-Other Reason for Withdrawal	OTHER	
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	(L32)	2. DETERMINATION 11/07/2016	N OF APPROVAI	L DATE (L33)	DETERMINATION APP	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245454

December 16, 2016

Mr. Michael Hedrix, Administrator Essentia Health - Sandstone Medical Center 109 Court Avenue South Sandstone, Minnesota 55072

Dear Mr. Hedrix:

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 26, 2016 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Weath

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

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 4, 2016

Mr. Michael Hedrix, Administrator Essentia Health - Sandstone Medical Center 109 Court Avenue South Sandstone, Minnesota 55072

RE: Project Number S5454026

Dear Mr. Hedrix:

On September 16, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 1, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On October 31, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 1, 2016, effective September 26, 2016 and therefore remedies outlined in our letter to you dated September 16, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	г	
IDENTIFICATION NUMBER	A. Building				
245454 _{Y1}	B. Wing	Y2	10/31/2016	Y3	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER		109 COURT AVENUE SOUTH			
		SANDSTONE, MN 55072			

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

ITEI	W	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0176	Correction	ID Prefix	F0242		Correction	ID Prefix	F0248		Correction
Reg. #	483.10(n)	Completed	Reg. #	483.15(b))	Completed	Reg. #	483.15(f)(1)		Completed
LSC		09/23/2016	LSC			09/23/2016	LSC			09/23/2016
ID Prefix	F0278	Correction	ID Prefix	F0282		Correction	ID Prefix	F0309		Correction
Reg. #	483.20(g) - (j)	Completed	Reg. #	483.20(k	:)(3)(ii)	Completed	Reg.#	483.25		Completed
LSC		09/26/2016	LSC				LSC			09/26/2016
ID Prefix	F0314	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.25(c)	Completed	Reg. #			Completed	Reg. #			Completed
LSC		09/26/2016	LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #			Completed	Reg.#			Completed
LSC			LSC			_	LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) TA/mm	DATE 11/04/2	I	SIGNATURE OF S	URVEYOR	29433		DATE 10/3	1/2016
REVIEWED BY CMS RO (INITIALS)		DATE		TITLE			DATE			
FOLLOWUP TO SURVEY COMPLETED ON 9/1/2016			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					YES NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	BNUW
Fac	ility ID: 00452

	TAKI I-	TO BE COMIT	DETED DI	IIIE SIAI	ESURVETAGENCI	Facility ID: 00432	
MEDICARE/MEDICAID PROVID (L1) 245454 GENERAL WENDER OF MEDICALD			HEALTH - SA	ANDSTONI	E MEDICAL CENTER	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification	
2.STATE VENDOR OR MEDICAID (L2) 475213900	NO.	(L4) 109 COURT (L5) SANDSTON		ОГП	(L6) 55072	3. Termination 4. CHOW 5. Validation 6. Complaint	
	OWNEDCHID			CODY		7. On-Site Visit 9. Other	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	O5 HHA	JORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint	
` ′	1/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING DATE: (L35) 09/30	
2 AOA 3 Other		04 5111	00 01 1/31	12 KHC	10 HOSI ICE	37.20	
11. LTC PERIOD OF CERTIFICATIO From (a): To (b):	N	Compliance		AS:	And/Or Approved Waivers Of2. Technical Personnel3. 24 Hour RN 4. 7-Day RN (Rural SN	6. Scope of Services Limit 7. Medical Director	
12.Total Facility Beds	45 (L18)	1. A	ecceptable 1 OC		5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	45 (L17)	X B. Not in Con Requirements	mpliance with Pro and/or Applied	_	* Code: B*		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 45	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Susan Frericks, HPR SW	Susan Frericks, HPR SWS 0926/2016 (L19)			(L19)	Mark Meath		(L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBITE _X_ 1. Facility is Eligible to			MPLIANCE WITH	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)	
2. Facility is not Eligible	-				5. Both of the Above .		
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE!	MENT	26. TERMINATION ACTION	(L30)	
OF PARTICIPATION 04/01/1987	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	07-Provider Status Change	
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29). INTERMEDIARY	/CARRIER NO.		30. REMARKS		
	(7.00)	03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 16, 2016

Mr. Michael Hedrix, Administrator Essentia Health - Sandstone Medical Center 109 Court Avenue South Sandstone, Minnesota 55072

RE: Project Number S5454026

Dear Mr. Hedrix:

On September 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Teresa.Ament@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 11, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 1, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by March 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 10/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (X3	B) DATE SURVEY COMPLETED
		245454	B. WING _		09/01/2016
	PROVIDER OR SUPPLIER	ONE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F 000	INITIAL COMMENT The facility's plan of as your allegation of Department's accept enrolled in ePOC, you at the bottom of the form. Your electronic be used as verificated. Upon receipt of an accommendation on-site revisit of your validate that substated regulations has been your verification. 483.10(n) RESIDENDRUGS IF DEEME An individual reside the interdisciplinary §483.20(d)(2)(ii), has practice is safe.	of correction (POC) will serve frompliance upon the otance. Because you are our signature is not required first page of the CMS-2567 created submission of the POC will ion of compliance. Cacceptable electronic POC, and are facility may be conducted to not acceptable with the en attained in accordance with	F 00	DEFICIENCY)	9/23/16
	3 residents (R12) o of a nebulizer treatr Findings include: R12's Hospital Disc 8/24/16, included di pneumonia, nausea (difficulty or discom failure to thrive.	of medications (SAM) for 1 of bserved for self-administration nent. harge Summary dated scharge diagnoses of a and vomiting, dysphagia fort with swallowing) and		if deemed safe: Element #1: Resident #R12 was reviet for appropriateness of SAM & SAM assessment was completed on 8/30/2 along with MD order for resident to SA Resident # R12 was again re-assesse for appropriateness on 9/8/16 after returning from hospitalization & was for appropriate to SAM nebulizer after set by nursing with checks for compliance completion of medication.	ound i-up
ABORATOR'	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

09/26/2016

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED
		245454	B. WING _		09/0	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		1,1010
ESSENT	IA HEALTH - SANDS	TONE MEDICAL CENTER		109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 176	Continued From page	age 1	F 17	76		
	indicated R12 was Interview for Menta Assessment for M short and long terr moderately impaired did not have any b R12 needed the exwith activities of day a Communication 8/25/16, the physic milligrams (mg)/3 inhaled medication airways and increatimes a day for 10 medical record lac nebulizer treatment On 8/29/16, at 1:30 in his room in the NThe nebulizer was R12 appeared to be nurse (LPN)-B was nursing desk and the hall. LPN-B did 1:41 p.m. when shother staff in the hall of the nebulizand R12 appeared medication cart at the interim director R12's room to the	/Information Fax Sheet dated sian ordered albuterol 2.5 mililiters (ml) nebulizer (an a that relaxes muscles in the ases air flow to the lungs) four days. The order and the ked an order to SAM the		Element #2: All other reside potential to be affected by the practice have been reasses appropriateness. Element #3: To prevent this happening again, education to the nurses on duty on 8/3 passed through report. The admission/re-admission reswas updated to address if a needs to have a SAM compadmit/re-admit. Nursing stareminded of the SAM policy Friday news publication on 9/9/2016. Nursing staff wer 9/19/16 at mandatory meeting importance of making sure obtained for residents & if renot have a SAM they may resident alone with medicat facility Sam policy was reviewed. Element #4: To maintain conself-Administration of medical Resident Care Coordinator will review all residents with SAM each month x 3 month need based upon findings. Coordinator or designee will admits/re-admits to see if the for a SAM & appropriateness resident to SAM. Nursing Sereminded of SAM policy months via Friday notes pur Negative findings will be repon to the policy months via Friday notes pur Negative findings will be repon to the property of the policy months via Friday notes pur Negative findings will be repon to the property of the policy months via Friday notes pur Negative findings will be repon to the property of the policy months via Friday notes pur Negative findings will be reponents.	his deficient seed for a from a was provided 30/2016 and bident checklist a resident oleted upon ff were a weekly 9/2/2016 & re educated on ing of a SAM was esident does not leave tion. The ewed. Impliance with cation the or designee a current as, then as Resident Care II review all here is a need as of each taff will be onthly x 3 blication. Corted to the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245454	B. WING			09/	01/2016
	PROVIDER OR SUPPLIER	ONE MEDICAL CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 09 COURT AVENUE SOUTH ANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	room across the hat LPN-B exited the rocheck on R12 and returned to the med 10:26 a.m. LPN-B looked in and contitute walked back periodication cart at the entered R12's room you're done" and closs of the medication cart at the entered R12's room you're done" and closs of R12 alone with the LPN-B stated she ut treatment, leaves here turns and remove when it was done. On 8/30/16 at 4:10 R12 had the nebulit observed he was domask. The DON state him so they got the for SAM today. The stay with the reside SAM the nebulizer, the hospital on 8/22 a resident was okay the medication admincluded in the care. The facility's Self-A policy dated 8/28/13 to assist the resider a safe manner and regarding their medication are of the drug, to fadministration are stated as a safe manner and regarding their medication are of the drug, to fadministration are stated as a safe manner and regarding their medication are of the drug, to fadministration are stated as a safe manner and regarding their medication are safe	all from R12. At 10:23 a.m. com across the hall but did not the nebulizer treatment. LPN-B dication cart at the desk. At walked past R12's room, nued to the end of the hall and past R12's room to the he desk. At 10:27 a.m. LPN-B h. LPN-B stated, "it looks like osed the door. I. p.m. LPN-B, verified she left nebulizer treatment running. It is usually set up the nebulizer im alone in his room and the nebulizer treatment. I. p.m. the DON stated she saw zer on this morning and oing fine with leaving the face ated the nebulizer was new for order and he was assessed to DON would expect staff to the nebulizer treatment from 14/16. The DON further stated if y to SAM it would be written on ininistration record (MAR) and	F 1	76	Element #5: The facility will be in fu compliance with F-176 by 9/23/201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245454	B. WING		09/0	01/2016
	PROVIDER OR SUPPLIER A HEALTH - SANDS	TONE MEDICAL CENTER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 09 COURT AVENUE SOUTH SANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176 F 242 SS=D	physician's order w 483.15(b) SELF-DE MAKE CHOICES The resident has the schedules, and her her interests, assessinteract with membinside and outside about aspects of his are significant to the This REQUIREME by: Based on interview facility failed to hon for 3 of 3 residents Findings include: R12's Face Sheet, included, hemipleg deficits following a and mild intellectual R12's quarterly Mir 7/13/16, indicated I had moderatively in also indicated he rephysically assist his R12's care plan da required assistance (ADL's) including by	esident to SAM and a ould be obtained. ETERMINATION - RIGHT TO the right to choose activities, alth care consistent with his or asments, and plans of care; the eright the community both the facility; and make choices is or her life in the facility that the resident. Now and document review the or bathing frequency choices (R12, R4 and R25). Indicated R12's diagnoses is, hemiparesis and language cerebral infarction (stroke),	F 176	F-242 (D) Self-determination Rig Make Choices: Element #1: Resident # R12, R4, R were added to the bath schedule for weekly baths Element #2: All other residents that potential to be affected by this deficient practice have been re-assessed for preference of how many baths they prefer in a week based on interview resident or family. Element #3: To prevent this from happening again, the Activities/Soci History form was updated to ask how many baths per week was preferred resident, Program Director of Activities/gnee will update Resident Care Coordinator or designee on resident preference. This form is completed	had cient would with ial bw d by ties or	9/23/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONST			(X3) DATE SURVEY COMPLETED	
		245454	B. WING			09/0	01/2016
	PROVIDER OR SUPPLIER	ONE MEDICAL CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 9 COURT AVENUE SOUTH ANDSTONE, MN 55072	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 242	R12's undated bath R12 preferred a bainformation on the formation on 8/30/16, at 11:4 stated R12 took two Tuesday and Saturn On 8/31/16, FM-A con Tuesday and Saturn On Experience on Tuesday and Saturn On Since moving to the formation on Monday, during On 9/1/16, at 9/1/16, at expensibility of have a different schresidents that recein now, and that is the second bath. Those bath in the evening discontinued baths Sunday close to a young of the formation of the fo	in preference card indicated th. The preference card lacked frequency of baths per week. 7 a.m. family member (FM)-A or showers a week at home, on day. confirmed that R12 had baths atturday at home, but took just to the facility. acility's bath schedule for R12 was scheduled for a bath the day shift. a.m., nursing assistant (NA)-D on have only one bath during sident wants an extra bath it is the afternoon shift and they nedule. There are only 2 we their baths in the evening eir only bath of the week, not a few two residents just prefer to an end of the week, not a few or esidents just prefer to an end of the week and a few or esidents just prefer to an end of the week and a few or esidents want and wear ago. In with a straight and their ges, so those are done by not the bath aide. E-B said the more than one bath a week,	F 2	442	admission, quarterly, annually & wisignificant changes. Staffing schechas been changed to meet the neet the resident is preferences for bat. The bathing preference card for earesident has been updated to incluip preferred number of baths/shower week. Element #4: To maintain compliant resident bathing preferences, DON designee will interview 2 - 3 reside weekly x 1 month, then 5 - 6 reside monthly x 2 months. Resident Card Coordinator or designee will follow resident or family member at care conferences to make sure resident preference is being followed. Negatindings will be reported to DON & quarterly quality meetings. Element #5: The facility will be in fucompliance with F-242 by 9/23/201	dule eds of hing. ach de their a ce with I or nts ents e-up with t ttive at	
		a.m. (NA)-D stated R12 hasn't hs, but she does remember					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245454	B. WING			09/	01/2016
	PROVIDER OR SUPPLIER	ONE MEDICAL CENTER		109	REET ADDRESS, CITY, STATE, ZIP CODE 9 COURT AVENUE SOUTH ANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	R12 saying he took Saturday when livin On 9/1/16, at 11:47 (DON) said if a resi the facility would achowever, the DON have a mechanism about this preferenci initiate the request. A policy on preferer requested but not possible the requested but not possible the pulmonary disease kyphosis, glaucoma The quarterly Minin 7/15/16, indicated Fimpairment, behavineeded the extensi activities of daily living one staff with particular ones a week, at home. "I've alway my hair every day, would like a bath minimal was not offer or informore than once a with staff was so busy sanother bath. The Activities Social Assessment dated important to choose	a bath on Monday and g at home. a.m. the director of nursing dent asked for an extra bath, commodate the request. did say the facility did not in place to ask residents ce; residents would have to access of bathing frequency was provided. Sheet indicated R4's chronic obstructive heart failure, depression, a and osteoporosis. The properties of the pro	F 2	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245454	B. WING		09/	01/2016	
	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	, 3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 242	The Bathing Prefer R4 preferred to tak liked to be assisted in the tub with the j Preference Card la number of baths in The Bath Scheduled to receive morning. On 9/1/16, at 9:10 stated R4 had not at the bath would have shift. NA-D further On 9/1/16, at 11:45 stated she does re R4 had not request week. R25's Resident Fardiagnoses included of the shoulder and eyelid) of bilateral expelicitly of bilateral expelicitly of the state of the total as bathing. On 8/29/16, at 4:10 received a bath one bath twice a week move in she received but then the schedule to take the schedule to the shoulder and the state of the total as bathing.	rence Card (undated) indicated to a bath with the jets on and did with bathing while she relaxed ets on. The Bathing tacked the preference of the a week. It (undated) indicated R4 was wed her bath on Tuesday a.m. nursing assistant (NA)-D asked for an extra bath and re to be done on the afternoon stated, "R4 loves her bath." It a.m. registered nurse (RN)-A sident care conferences and ted an another bath during the ce Sheet indicated R25's dimuscular dystrophy, bursitis diptosis (drooping of the upper	F 24:	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245454	B. WING			09/0	01/2016
	PROVIDER OR SUPPLIER IA HEALTH - SANDST	ONE MEDICAL CENTER		STREET ADDRESS, CITY, 109 COURT AVENUE S SANDSTONE, MN 55	оитн	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	received a bath once veryone received to a support the support that she was not asked changed. R25 stated day at home. R25 ft the facility for 4 years that she had week. The Customary Roddated 6/15/16, indicated 6/15/16, indicated R25 preference of the preference of the Dath Schedule to receive morning and her had the beauty shop. On 9/1/16, at 9:05 a schedules the resident was admitt open slot. NA-D fur have one bath on the extra bath they wou afternoon shift. R25 afternoons because the bath. R25 was approximately one management only a state of the state	ge 7 se a week. R25 stated their bath during the day. R25 he bath scheduled changed bey were doing. R25 stated or told why the schedule had so she took a shower every urther stated she has lived at rs and it had been a couple of been getting a bath one time a stated it was very important to bath. The assessment lacked he number of baths in a week. Sence Card (not dated) erred to take a bath with the greference Card lacked the umber of baths in a week. Into dated) indicated R25 was red her bath on Thursday hir was washed on Sunday in the stated residents can only he day shift and if they want an all dhave to have it on the she only wants NA-D to give very time consuming and took and a half hours to do so the allow NA-D give R25 one bath R25's hair only on Sunday.	F 2	42			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245454	B. WING		09/01/2016		
PROVIDER OR SUPPLIER	ONE MEDICAL CENTER		109 COURT AVENUE SOUTH			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
On 9/1/16, at 11:45 resident can have a 483.15(f)(1) ACTIV INTERESTS/NEED. The facility must proof activities designed the comprehensive the physical, mental of each resident. This REQUIREMENT by: Based on observative review, the facility for facilit	a.m. the DON stated a another bath in a week. ITIES MEET ITIES MEET ITIES OF EACH RES ITIES OF EACH RE		F-248(D) Activities meets interests of each resident: Element # 1: Activity Director review resident # 27 attendance record. It passed off in report the importance getting resident # 27 out of bed and Activities. Element # 2: All other residents that potential to be affected by this deficipractice have been reassessed for appropriateness. Element # 3: To prevent this from happening again Activity staff were educated by Activity Director on 9/7 and all staff was educated on 9/19// the all staff neighborhood meeting. NAR S will have resident # 27 up 1 groups, NAR sheets were updated each resident that participates in Se	wed was of d to thad sient 7/2016 2016 at for all for ensory	9/23/16	
R27's Care Plan da	ted 6/15/16, specified R27					
	Continued From pa On 9/1/16, at 11:45 resident can have a 483.15(f)(1) ACTIV INTERESTS/NEED The facility must pro of activities designe the comprehensive the physical, menta of each resident. This REQUIREMEN by: Based on observat review, the facility fa (R27) was allowed the fullest extent po Findings include: R27's Face Sheet p diagnoses including and major depress R27's quarterly min 6/16/16, indicated F cognition. R 27 car understands. R27's inattention comes a documentation of b The MDS indicated staff for transfers, e toileting. The MDS extensive assistance bed mobility.	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R27) was allowed to participate in activities to the fullest extent possible. Findings include: R27's quarterly minimum data set (MDS), dated 6/16/16, indicated R27 had severely impaired cognition. R 27 can be understood and usually understands. R27's MDS also indicated inattention comes and goes, but there was no documentation. The MDS indicated R27 required extensive assistance with personal hygiene and toileting. The MDS indicated R27 required extensive assistance with personal hygiene and	A BUILDING 245454 B. WING PROVIDER OR SUPPLIER A HEALTH - SANDSTONE MEDICAL CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 On 9/1/16, at 11:45 a.m. the DON stated a resident can have another bath in a week. 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R27) was allowed to participate in activities to the fullest extent possible. Findings include: R27's Face Sheet printed 8/31/16, indicated diagnoses including hemiplegia following CVA, and major depression. R27's quarterly minimum data set (MDS), dated 6/16/16, indicated R27 had severely impaired cognition. R 27 can be understood and usually understands. R27's MDS also indicated inattention comes and goes, but there was no documentation of behaviors or rejection of cares. The MDS indicated R27 is totally dependent on staff for transfers, eating (gastronomy tube) and toileting. The MDS indicated R27 required extensive assistance with personal hygiene and bed mobility.	### PROVIDER OR SUPPLIER A HEALTH - SANDSTONE MEDICAL CENTER	### PROVIDER OR SUPPLIER ### A HEALTH - SANDSTONE MEDICAL CENTER ### A HEALTH - SANDSTONE MEDICAL CENTER ### SUMMARY STATEMENT OF DEPICIENCIES SUMMARY STATEMENT OF DEPICIENCIES 109 COURT AVENUE SOUTH SANDSTONE, MM 55072 SUMMARY STATEMENT OF DEPICIENCIES 109 COURT AVENUE SOUTH SANDSTONE, MM 55072 SUMMARY STATEMENT OF DEPICIENCIES 109 COURT AVENUE SOUTH SANDSTONE, MM 55072 Continued From page 8 100 On 9/1/16, at 11:45 a.m. the DON stated a resident can have another bath in a week. 483.15()(11) ACTIVITIES MEET F248 Continued From page 8 F248 Continued From page 8 F249 PRICE PROVIDER STAND OF CORRECTION CROSS REFERENCED TO THE APPROPRIATE DEPICE OF THE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245454	B. WING		09/0	01/2016
_	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	,	.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 248	would answer simple could put together at time. The care plar makes himself und information. The caprompting was need room. The care plar out of his room sevilisten to peers and directed staff to brig activity was occurring on a 1:1 program participates in the State care plan directed Gunsmoke daily at the activity room where the indicated R2 was to be up in a work the group sheet all participates in "ster and Thursdays. On 8/30/16, at 2:54 recliner in his room on the TV in his room on the TV in his room on the TV in his room, other resider room in preparation. On 8/30/16, R27 wasleep with the TV.	she yes or no questions and short sentences when given a also indicated R27 usually terstood and understand are plan also indicated much aded to get R27 out of his an directed staff to bring R27 reral times a day to watch and staff. The care plan also ang R27 to whichever group and when he was awake; R27 a with activities staff; and R27 Sensory Stem program. Finally, and the R27 liked to watch and a watch a watch a watch and a watch and a watch a	F 248	were updated and implemented. updated of the Sensory Stimulation days and times and what to do if refuses group via Friday notes pron 9/9/16. Element # 4: To maintain compliance activities to meet the interests and feach resident the Activities Dir Designee will audit 3 residents whom 1 month, 2 residents weekly for 2 and as needed for 3 months. Act Director/Designee will follow up a conferences with resident or fam member to ensure resident is attentiated activities of interest and discuss attendance. Activity Director will adjustments as needed in residence activity planning. Policies were reand updated by staff on 9/20/201 Element # 5: The facility will be incompliance with F-248 by 9/23/20	on group resident ublication ance for d needs ector or eekly for months ivities at care illy ending make nts viewed 6.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245454	B. WING			09/	01/2016
	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 09 COURT AVENUE SOUTH 6ANDSTONE, MN 55072	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 248	awake in bed, with From 8/31/16 at 8: variety of activities -residents were in independent activinewspaper, colorir-residents were sit waiting for their tur were coming and g-3 residents were activity to begin. On 8/31/16, at 9:0 entered R27's roor and reposition R27 waiting for someor would check him adonned gloves, gas supplies to check engage R27 in coruntil 9:18 a.m. who forgot about me ar assistance. NA-B a.m., at which time repositioned R27 in NA-A and NA-B wathe lights, left the notime did either out of bed or out on ot engage R27 in of checking, change On 8/31/16, at 9:25	7 a.m. R27 was observed the TV on. 251 a.m. until 9:08 a.m. a were occurring in the facility: the activity room doing ties (cards, reading the ng) ting outside the nurses station on at the beauty shop and staff going. In the bird room waiting for an	F 2	248			
	assistance. NA-B a.m., at which time repositioned R27 i NA-A and NA-B was the lights, left the no time did either out of bed or out on not engage R27 in of checking, changed On 8/31/16, at 9:20 gets out of his room	returned with NA-A at 9:20 e they checked, changed and n bed. After performing cares, ashed their hands, turned out IV on and left R27's room. At NA-B nor NA-A offer to get R27 f his room. NA-B and NA-A did conversation beyond the task ging and repositioning.					

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ONE MEDICAL CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 19 COURT AVENUE SOUTH ANDSTONE, MN 55072	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	if he would like to g R27 quickly nodded On 8/31/16, at 11:0 (LPN)-B exited R27 bed. LPN-B returne medications in R27 On 8/31/16, at 1:05 bed and the room v curtain pulled close On 8/31/16, at 1:06 R27 into his recline get him up once too best time for R27. On 8/31/16, at 1:46 bored, R27's eyes v head, "yes." When out more, R27 agai Review of R27's ac -The last time R27 activity Sensory Sta July and August of were noted. During June of 201 -4 days where his con- esting, napping or -10 days with family -10 days of facility (one-on-ones, mus	et out of his room more often, d his head, "yes." 3 a.m. licensed practical nurse "s room. R27 remained in ed at 11:09 a.m. to give 's feeding tube. p.m. R27 was observed in was dark (lights off, window d). p.m. NA-B stated staff will get r now and afternoon shift will b. NA-B stated those are the p.m., when asked if he gets widened and he nodded his asked if he would like to get n nodded his head, "yes." tivities participation revealed attended the care planned em was 6/24/16. During June, 2016, only 2 activity refusals 6, R27 had: only activity was listed as TV only activity was listed as sleeping. Y or friends visiting activity involvement ic, etc.)	F 2	448			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER	-	STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 248	listed as rest, napproved the control of the contro	here R27's only activities were bing or sleep om 7/3/16 through 7/8/16 ed, slept or watched TV in his illy or friends visiting activity involvement. R27 had: the where his only activity was where his only activity was resting. illy or friends visiting involvement. 7 p.m. Activity Director (AD)-A are plan states to assist him all activities. AD-A stated she onversations with nursing and and them to also get R27 ready have him up for games, but it D-A stated nursing indicated me out but if approached, as cated, as let's just go do this o), R27 will enjoy himself once ore socialization. AD-A stated to fone on one activities with hem don't get charted. stop and chat with R27 if they	F 248			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ONE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
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F 248	6/2014, indicated reencouraged and give	ut of his room. es Program policy dated esidents of the facility shall be ven equal opportunities to	f 24	P8		
F 278 SS=D	that resident are infactivities are occurrinvolved and physic addition, this policy do no meaningful a approach and offer or acceptance is to acceptance and/or in the care plan. 483.20(g) - (j) ASSI	policy, dated 6/2014, indicated formed of when group ring and are encouraged to be cal assistance is provided. In indicted if resident appears to ctivity per their choice, staff activities. Resident's refusal be documented. Patterns of refusals are to be documented	F 27	78		9/26/16
	resident's status. A registered nurse reach assessment with participation of heat assessment is comparted in a session of the attention of th	Ith professionals. must sign and certify that the pleted. completes a portion of the sign and certify the accuracy of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245454	B. WING		09/01/2016	
	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 09 COURT AVENUE SOUTH 6ANDSTONE, MN 55072		
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F 278	\$1,000 for each as willfully and knowir to certify a materia resident assessme penalty of not more assessment. Clinical disagreem material and false This REQUIREME by: Based on observareview, the facility Minimum Data Set (R5) reviewed for Naily Living (ADLs). Findings include: On 08/31/2016, at walking down the Proom. A nursing as belt with a nurse was wheelchair. R5 was expressed she was wheelchair at whice aide into the dining. R5 had diagnoses and mobility abnorindicated on the Regolity of the unit, however to 7/21/16, indicated assistance. In additional contents of the dissistance. In additional contents of the contents	sessment; or an individual who ngly causes another individual I and false statement in a ent is subject to a civil money than \$5,000 for each ent does not constitute a statement. NT is not met as evidenced extion, interview and document failed to accurately code the (MDS) for 1 of 3 residents MDS accuracy for Activities of hallway towards the dining existant was holding R5's gait alking slowly behind R5 with a liked approximately 25 feet, as tired, sat down in the holding showly behind by the	F 278	F 278 (D) Assessment Accuracy/Coordination/Certified: Element #1: Resident #5 Annual ME dated 4/21/16 and MDS dated 7/21/were modified to accurately reflect locomotion on the unit. Element #2: For other residents who be affected by this practice a review admission, and/or quarterly assessmill be completed to ensure ADL functional status is accurate. Upon completion of the review any concerbe forwarded to the IDT Team for foup. Element #3: The policy for MDS coowas implemented by the interdiscipl team on (09/23/16). The Interdiscipl members were trained as it relates to respective roles and responsibilities regarding the audit tools and the ME policy and procedures on (09/23/20). Element #4: 4 Random MDS ADL and the ME policy and procedures on (09/23/20).	on may of of ments rns will ollow ding inary linary to their occurrence occ	

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		245454	B. WING		09/01/2016	
	PROVIDER OR SUPPLIER A HEALTH - SANDST	ONE MEDICAL CENTER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 09 COURT AVENUE SOUTH SANDSTONE, MN 55072		
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F 278	MDS dated 7/21/16 extensive assistance. On 9/1/16, at 2:30 p. Nursing (DON) produced A/21/16 and 7/21/16 this data prior to co-collection tool indicassistance for both from 4/15/16 to 4/2 7/21/16. During interview on stated a consultant	ne unit, however the Quarterly is, indicated R5 required	F 278	on scheduled assessments will be completed prior to transmission me for 3 months, and then quarterly for to ensure compliance with results reported to the QA/QI Committee for review and further recommendation. Further system revision and staff education will be provided if indicate audits. Negative findings will be reported to DON or designee. Element # 5: The facility will be in force compliance with F-278 by 9/26/2010.	or 1 year for ns. ted by poorted	
F 282 SS=D	based on the data of been coded extens on and off the unit is coded correctly. Do coded the 4/21/16 A verified there was not 483.20(k)(3)(ii) SEPPERSONS/PER CATTHE SERVICES provided by accordance with eacure. This REQUIREMENT by: Based on observative review the facility fare.	collected, R5 should have ive assist for both locomotion in April and that July was DN verified the MDS staff Annual MDS incorrectly. DON to MDS coding policy. RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in inch resident's written plan of NT is not met as evidenced tion, interview and document ailed to provide care and	F 282	F-282 (D) Services by qualified persons/per care plan:	9/26/16	
		d by the care plan for pressure for 1 of 3 residents R8		Element #1: Staff on duty was noti	fied of	

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	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 09 COURT AVENUE SOUTH SANDSTONE, MN 55072		
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F 282	reviewed for pressure ulcers. In addition, the facility failed to ensure 1 of 2 residents (R27) was		F 282	importance of following plan of care resident #R8 by offloading/repositio		
	included in activitie directed by the care Findings include:	es outside of his room as e plan.		as directed by POC & asking for assistance when needed. Staff on was notified of importance of follow plan of care for resident #R27 of ge	ing	
	R8's Face Sheet dated 8/31/16, indicated R8's diagnoses included hemiplegia and hemiparesis following cerebrovascular disease (stroke) affecting the right side, aphasia (inability to comprehend and formulate language because of dysfunction in specific brain regions. Most often caused by a cerebral vascular accident), long term anticoagulant use, pressure ulcer on the buttocks and pain. The Skin Care Plan dated 9/5/14, indicated R8 had a history of pressure ulcer on the left and right buttock and had a current pressure ulcer on the buttock. The care plan directed staff to reposition R8 side to side every hour to reduce pressure on the buttocks due to skin breakdown. R8 was to be one of the last residents in the dining room and one of the first residents out of the dining room due to hourly repositioning. The undated nursing assistant (NA) care guide directed the NAs to reposition side to side or offload every hour. On 8/31/16, R8 was continuously observed from 7:05 a.m. until 9:01 a.m. when R8 put on the call light on to lay down. At 7:25 a.m. R8 was observed up in the wheelchair dressed for the day. At 7:35 a.m. NA-C brought R8 to the main dining room (MDR) and placed him at the table. At 8:35 a.m. R8 was done eating and wheeled himself back to his			him out of bed & to activities. Element #2: All other residents that potential to be affected by this defic practice have been reassessed for appropriateness. Element #3: To prevent this from happening again, education was protostaff on duty on 8/31/16 & passed through report. Staff was also remir importance on 9/2/16, 9/9/16 and 9/1/16 was educated by Activity staff was educated by Activity Director on 9/7/16 & all staff was educated on 9/19/16 at the all staff neighborhood meetings. The facility policy and procedure on Care Plant was reviewed & updated.	had ient ovided d nded of /23/16 s. ty	
				Element #4: To maintain compliance Services by qualified persons/per caplan the Resident Care Coordinator Activity Director (or their designee) review 5 residents plan of care, of the department, each month x 3 months as need based upon findings. Residente Care Coordinator or designee will p 5 audits of nursing staff with following of care each month x 3 month then need based upon findings. Activity Director or designee will perform 5 and activity staff with following plan of	are · & will heir s then dent erform ng plan as audits	

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		245454	B. WING			09/0	01/2016
_	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 19 COURT AVENUE SOUTH ANDSTONE, MN 55072		
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F 282	television until 9:01 light. NA-C entered they were going to got up in the wheel was when R8 usual breakfast. NA-C veor offloaded every returned to his roor assisting at breakfa onto the bed with the On 8/31/16, at 9:45 DON verified R8 wooffloaded every how hourly repositioning. MDR and first ones eating the NA shou offer repositioning, would expect staff the NAs were unabtime she would expect staff the NAs were unabtime she would expect or reposition reside also help transfer roor The facility was unafollowing the care pure Based on observative review, the facility of (R27) was included room according to Findings include:	d in the wheelchair watching a.m. when R8 put on the call at the room and reassured R8 lay him down. NA-C stated R8 chair at about 7:30 and that ally went to the MDR for erified R8 was to repositioned one hour. NA-C was aware R8 m at 8:35 a.m. but she was still ast. R8 was then transferred the mechanical lift. 5 a.m. the director of nursing as to be repositioned or ur. The residents who were a should be the last ones in the sout. If the resident was still ald approach the resident and The DON further stated she to follow the care plan and if the ble to get to the residents in the sents and the activity staff can esidents. The provide a policy on the policy on the control of the policy on the policy on the control of the policy on the policy on the control of the policy on the poli	F 2	282	each month x 3 months then as ne based upon findings. Negative find will be reported to the DON & report quarterly quality meetings. Element #5: The facility will be in fucompliance with F282 by 9/26/2016	ings ted at	

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	PROVIDER OR SUPPLIER	ONE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 282	R27's quarterly min 6/16/16, indicated F data set (MDS), da severely impaired of understood and usindicated inattention was no documentate of cares. The MDS dependent on staff (gastronomy tube) indicated R27 requipersonal hygiene a R27's Care Plan dausually made himse information and indicated to get R27 staff to bring R27 oday to watch and list care plan also direct whichever group at was awake, that R2 activities staff and pStem program. Find R27 liked to watch Review of R27's graph R27 out of bed at let the activity room whichever also directs significantly in a wheelch sheet also directs significantly in a wh	simum data set (MDS), dated R27 R27's quarterly minimum ted 6/16/16, indicated R27 had cognition, but could be ually understands. R27's MDS in comes and goes, but there tion of behaviors or rejection indicated R27 is totally for transfers, eating and toileting. The MDS ired extensive assistance with and bed mobility. Inted 6/15/16, indicated R27 relif understood and understand icated much prompting was out of his room, and directed ut of his room, and directed ut of his room several times a sten to peers and staff. The ceted staff to bring R27 to citivity was occurring when he extensive as on a 1:1 program with carticipates in the Sensory ally, the care plan indicated Gunsmoke daily at noon. Toug sheet directed staff to get east twice daily and bring to nile out of bed. The group of like to people watch and is to air for every activity. The group staff that R27 participates in	F 2	82			

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F 309 SS=D	-The last time R27 activity Sensory Ste July and August of were noted. On 8/31/16, at 1:47 confirmed R27's care out of his room for numerous attempts follow R27's care p following R27's acti 483.25 PROVIDE CHIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psychological sensors activities and psychological sensors activities activities and psychological sensors activities activ	tivities participation revealed: attended the care planned em was 6/24/16. During June, 2016, only 2 activity refusals p.m., Activity Director (AD)-A are plan stated to assist him all activities. AD-A stated had been made to get staff to lan, but verified staff are not vities care plan. CARE/SERVICES FOR	F 28		9/23/16
	by: Based on interview facility failed to coo hospice provider ar residents (R30), rev. Findings include: R30's face sheet prodiagnoses that include upper-outer quadra malignant neoplasr	or and document review the redinate care between the red the facility for 1 of 1 viewed for hospice. Finted 9/1/16, indicated uded malignant neoplasm of ant of right breast, secondary of brain, secondary of liver and intrapatic bile		F-309 (D) Provide care/services for highest well being: Element #1: Resident Care Coordinate spoke with RN Case Manager for Resident #R30 to coordinate care. Element #2: Resident Care Coordinate has coordinated care for all other residents that had potential to be affectly this deficient practice.	ator

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F 309	duct, and encounted to R30's Hospice C signed on to hospice R30's quarterly Mir 7/7/16, indicated R mean a life expect. The MDS also indicated repression. R30's Care Plan, of hospice for end of for a diagnosis of relative Interventions included facility, registered reand for the hospice care needs weekly staff was already per Review of the nurse R30 states "hospice lacked direction on facility. On 8/30/16, at 4:58 stated she doesn't they just show up. nurse "pops in" a fed doesn't really know On 8/31/16, at 10:0 (NA)-A stated she doesn't really know On 8/31/16, at 10:0 (NA)-A stated she doesn't know when or what they'll be doesn't know when or what they'll be doesn't be signed as a stated when they'll be doesn't know when or what they'll b	er for palliative care. According Care Plan, dated 3/30/16, R30 ce on 2/21/16. nimum Data Set (MDS) dated 30 had a prognosis that may ancy of less than 6 months. cated R30 suffered from lated 3/30/16, indicated life care beginning on 2/21/16, netastatic breast cancer. ded to coordinate care with the nurse and care coordinator, a aide to provide additional above the cares the facility	F 309	Element #3: To prevent this from happening again, Resident Care Coordinator or designee will spea hospice residents RN Case Mana hospice schedule Q monthly and of schedule will be placed in staff room for all staff to see. Resident Coordinator has spoken to hospic Case Manager about updating he any changes to the schedule. Hopolicy was implemented. Element #4: To maintain compliar provide care/services for highest well-being the Resident Care Coor designee will audit hospice scha month for 3 months & as need based on findings. Negative finding be reported to the DON & reported quarterly quality meetings. Element #5: The facility will be in compliance with F-309 by 9/23/20	ager for calendar report Care ce RN er with expice make with ordinator redule 3x passis ags will dat	

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NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER				10	TREET ADDRESS, CITY, STATE, ZIP CODE 09 COURT AVENUE SOUTH ANDSTONE, MN 55072	, , ,	.,
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F 309	when they'll come of On 8/31/16, at 10:0 was found for R30 behind the facility in chart revealed hosp on Tuesdays, and of scheduled to visit. It day to expect this scalendar was blank On 8/31/16, at 10:2 (LPN)-B stated she are coming, "When maybe administration hospice, but she do On 9/1/16, at 2:00 p the hospice nurse a know how staff wou are coming. On 9/1/16, at 2:00 p nursing (DON) state monthly calendar in did not know if the state of they looked at the sinformation was not go to gather information was not go to gather information was not go to gather agencies set days. RN-A state R30's the facility so staff with the afternoon become alert and awainformation was known and the state of the sta	7 a.m. a green hospice chart locked in the med room ursing station. Review of this pice aides come to the facility on Fridays an RN was The schedule lacked a time of taff and the September. 0 a.m. licensed practical nurse knows when hospice nurses they show up." LPN-B stated on knows when to expect pesn't know in advance. c.m., RN-A stated she talks to about once a week, but didn't all know when hospice staff on the hospice agencies put a part the hospice chart. The DON staff were aware of this or if schedule. The DON stated this tail the report room where staff action at the start of their shifts. The hospice agency was new to wouldn't know their days, but that work at the facility have ed R30's hospice staff come cause that is when R30 is ke. RN-A did not know if this	F3	809			

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F 309 F 314 SS=D	483.25(c) TREATM PREVENT/HEAL P Based on the compresident, the facility who enters the facility who enters the facilidoes not develop p individual's clinical at they were unavoidal pressure sores recesservices to promote prevent new sores. This REQUIREMENT by: Based on observation review, the facility for the	eceived from the facility. ENT/SVCS TO RESSURE SORES brehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced ion, interview and document ailed to provide timely ding to the resident's prevent the development of 1 of 3 residents (R8) reviewed less defined by the National sory Panel. Injury: Partial-thickness skin dermis. Is of skin with exposed bed is viable, pink or red, or present as an intact or	F 30	F-314 (D) Treatment/SVCS to prevent/heal pressure sores: Element #1: Staff on duty was inform importance of offloading/repositionin resident #R8 as directed by plan of and asking for assistance when need Element #2: All other residents that I potential to be affected by this deficie practice have been re-assessed by Resident Care Coordinator Element #3: To prevent this from happening again, education was proto staff on duty on 8/31/16 & passed	g care ded. nad ent vided	
	diagnoses included	ated 8/31/16, indicated R8's hemiplegia and hemiparesis scular disease (stroke)		through report. Staff was also remine importance on 9/2/16, 9/9/16 and 9/2 via weekly Friday news publications. was also educated on 9/19/2016 at t staff neighborhood meetings. The fa	23/16 Staff he all	

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F 314	affecting the right secomprehend and for dysfunction in specicaused by a cerebic kidney disease, dyswith swallowing), lour pressure ulcer on the quarterly Minin 6/20/16, indicated location, staff name in a nursing home. Or rejection of care assistance of 2 statoilet use and personal to the pressure ulcers and always inconting for pressure ulcers two pressure ulcers two pressure ulcers two pressure ulcers and healed pressure ulcers and was on a turning. The significant characteristic pressure ulcers put him at risk which and required the associationally inconting previous CVA with history of pressure of the bed up when a right hand contral and was on Couma medication), which bruising. R8 had a	age 23 side, aphasia (inability to ormulate language because of offic brain regions. Most often ral vascular accident), chronic sphasia (difficulty of discomfort ong term anticoagulant use, the buttocks and pain. Inum Data Set (MDS) dated R8's long term memory was to recall the season, his room the sand faces and knew he was R8 did not have any behaviors and faces and knew he was R8 did not have any behaviors are required the extensive ff with bed mobility, transfers, and hygiene. R8 did not walk. In retremities were impaired on requently incontinent of urine the nent of bowel. R8 was at risk and had one unhealed stage. The oldest date of the refulcers. R8 had a pressure the bed and the wheelchair the gand repositioning program. Inge Care Area Assessment repositioning program. Inge Care Area Assessment regard included: limited mobility sistance of two staff, included: limited mobility sistance of two staff, inent of bowel and bladder, right sided hemiplegia, a ulcers, R8 requested the head a sleeping for comfort and had cture. He had atrial fibrillation and in (a blood thinning put R8 at increased risk of ROHO (pressure reducing air) the rand a pressure reducing air) ther and a pressure reducing air) the rand a pressure reducing air) the rand a pressure reducing air) there and a pressure reducing air) the rand a pressure reducing air) the rand a pressure reducing air)	F3	policy and procedure on pressult was reviewed. Element #4: To Maintain comple F 314, the RN or Wound Care on urse will audit all residents with ulcers monthly X 3 months, the X 3 months then on a as needed. The audit will consist of complet tissue tolerance, skin/braden as dietician consult and MD notific negative findings will be reported. DON and at the quarterly quality meetings. Element #5: The facility will be compliance with F-314 by 9/26/	ance with Certified In pressure In quarterly Id basis. Ition of Issessment, Ition. All Id to the		

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F 314	offloaded and repo A Skin Assessmen used to determine Tolerance Assessmen the ability of the sk to endure the effect effects) dated 6/7/pressure ulcers. Rimobility, occasiona (stroke) which afferequested to sleep elevated and had a was to be offloaded area for a minimum repositioned every A Progress Note daright buttock had to areas with a periword the wound) which wound which wound which wound which wound which wound which wound which were: 1) A T-shaped scall buttock which mea 2) On the upper rig scabbed area which The current treatm Prep (a barrier wip cream) every shift. A Skin Assessmen indicated R8 had dright buttock under had two scab-like a Measurements we	n in wheelchair. R8 was to be sitioned every two hours. It with a Braden Scale (a tool pressure ulcer risk) and Tissue hent (a tool used to determine in and its supporting structures its of pressure without adverse 16, indicated R8 was at risk for sk factors included; limited all incontinence, a previous CVA cted his right side, R8 with the head of the bed a history of pressure ulcers. R8 dd (to relieve pressure to an in of one minute) or one hour. Set at 8/30/16, indicated R8's wo small partial thickness bound (the tissue surrounding was purple in color and was eriwound measured 7 y 6 cm. Within the periwound cobed area on the lower right sured 1 cm by 1.5 cm. In the fight buttock was a high measured 0.5 cm by 0.5 cm. In the of the right buttock was a high measured 0.5 cm by 0.5 cm. In the order was to apply Skin the order was to apply Skin the land Calmoseptine (a barrier with hourly repositioning. The Progress Note dated 8/31/16, ry flaky skin throughout the the Calmoseptine cream. R8 areas on the right buttock.	F 314	4		

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NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH - SANDSTONE MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	, 33.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 314	was purple in color indicated the areas mixed etiology of I/d damage) along with and shear are mec pressure ulcer form resulting from these superficial skin injurant offloaded every. The Skin Care Plar was at risk for skin due to having right aphasia due to a part head of the bed be score indicated R8 pressure ulcers. Resulcer on the left and current pressure ul plan approaches in pressure reducing the recliner. A hone bed. The care plan reposition side to spressure on the burth R8 was to be one of dining room and on the dining room due. The undated nursing directed the NAs to offload every hour. On 8/31/16, R8 wa 7:05 a.m. until 9:01 light on to lay down	eriwound was blanchable and The progress note further were most likely a result of AD (incontinence associated in friction and shearing (friction hanical forces contributing to nation. The tissue injury is forces may look like a ry.) R8 was to be repositioned by hour. In dated 9/5/14, indicated R8 impairments or breakdown sided hemiparesis and last CVA. R8 requested the last CVA. R8 requested the last and last CVA. R8 requested the last and last CVA. The care of right buttock and had a last cer on the buttock. The care lactuded; a honeycomb cushion in the wheelchair and laycomb sheet at the foot of the further directed staff to lide every hour to reduce ttocks due to skin breakdown of the last residents in the last residents out of the to hourly repositioning. In assistant (NA) care guide or reposition side to side or	F 314				

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

PRINTED: 10/18/2016 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245454	B. WING		09/	01/2016	
	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 314	the room with the r was observed up in the day. At 7:35 a.m main dining room (table. Also present other residents. Mc 7:45 a.m. staff took a.m. R8 received hreceived his break medication from the done eating and wroom and remained television until 9:01 light. NA-C entered they were going to NA-C stated R8 go 7:30 and that was MDR for breakfast repositioned or offl was aware R8 retubut she was still as further stated she han every one hour reposition him also was then transferred mechanical lift. R8 cares. R8 was obswheelchair for 1 hobeing repositioned At 9:10 a.m. R8's to the interim director cleansed the area of the coccyx. The substance. The DC was Calmoseptine	At 7:10 a.m. NA-C entered mechanical lift. At 7:25 a.m. R8 in the wheelchair dressed for m. NA-C brought R8 to the MDR) and placed him at the in the dining room was 6-8 best of the tables were empty. At R8's breakfast order. At 7:55 his beverages. At 8:15 a.m. R8 fast. At 8:25 a.m. R8 received e nurse. At 8:35 a.m. R8 was heeled himself back to his d in the wheelchair watching a.m. when R8 put on the call d the room and reassured R8 lay him down. In the wheelchair at about when R8 usually goes to the analysis at breakfast. NA-C arned to his room at 8:35 a.m. seisting at breakfast. NA-C and another resident who was repositioning and she had to because he was late too. R8 and onto the bed with the was provided incontinence erved sitting up in the bur and 36 minutes without	F 31	4			

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

PRINTED: 10/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245454	B. WING			09/	01/2016
	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 09 COURT AVENUE SOUTH ANDSTONE, MN 55072	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Calmoseptine crea On 8/31/16, at 9:45 to be repositioned oresidents who were be the last ones in the resident was st approach the residents NAs to ask the nur and the activity staf residents. On 8/31/16, at 1:10 (LPN)-B stated if th with meals, they we every one hour rep On 8/31/16, at 1:15 times when R8 wer repositioning times every one hour rep sometimes they we busy with another r On 8/31/16, at 1:25 time they are unable every hour was dur the nurses if they a residents who require positioning.	he skin prep and the m to the area. So a.m. the DON verified R8 was or offloaded every hour. The enhourly repositioning should the MDR and first ones out. If still eating the NA should ent and offer repositioning. Stated if the NAs were unable to so in time she would expect the reses to reposition residents of can also help transfer. Dep.m. licensed practical nurse are NAs were busy or assisting build ask her to reposition the ositioning residents. Dep.m. NA-A stated there were not over the one hour. The NAs try to get to the ositioning residents in time but the easiesting with meals or esident. Dep.m. NA-B stated the only let to reposition or offload R8 ring breakfast. They can ask the unable to get to the	F3	14			
		ation policy revised 2/15,					

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

PRINTED: 10/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245454	B. WING	B. WING		/01/2016
	PROVIDER OR SUPPLIER	TONE MEDICAL CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COI 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	indicated residents	age 28 s were to be turned and ne Tissue Tolerance	F3	14		

Printed: 09/01/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 01 - MAIN BUILDING 01 COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245454 B. WING 08/30/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 109 COURT AVENUE SOUTH **ESSENTIA HEALTH - SANDSTONE MEDICAL (** SANDSTONE, MN 55072 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Essentia Health Sandstone Nursing Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Essentia Health Sandstone Nursing Home, is a 1-story building with a partial basement. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1988 an addition was constructed to the building that was determined to be of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the

corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code.

The facility has a capacity of 45 beds and had a census of 26 at the time of the survey.

The requirement at 42 CFR Subpart 483.70(a) is LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

Printed: 09/01/2016 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA BER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SUR COMPLETE			JRVEY TED
		245454		B. WING	08/30/2016		
	PROVIDER OR SUPPLIER FIA HEALTH - SAND	STONE MEDICAL (109 CO		TATE, ZIP CODE IUE SOUTH I 55072		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	Continued From particles Met.	age 1		K 000			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 16, 2016

Mr. Michael Hedrix, Administrator Essentia Health - Sandstone Medical Center 109 Court Avenue South Sandstone, Minnesota 55072

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5454026

Dear Mr. Hedrix:

The above facility was surveyed on August 29, 2016 through September 1, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

Essentia Health - Sandstone Medical Center September 16, 2016 Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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 Teresa Ament at (218) 302-6151 or email: teresa.ament@state.mn.us.

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

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

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

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 10/18/2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING _ 00452 09/01/2016

	PROVIDER OR SUPPLIER A HEALTH - SANDSTONE MEDICAL C	109 COUF	DRESS, CITY, S RT AVENUE : DNE, MN 55		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments		2 000		
	*****ATTENTION*****				
	NH LICENSING CORRECTION ORI	DER			
	In accordance with Minnesota Statute, 144A.10, this correction order has been pursuant to a survey. If, upon reinspect found that the deficiency or deficiencies herein are not corrected, a fine for each not corrected shall be assessed in account with a schedule of fines promulgated by the Minnesota Department of Health. Determination of whether a violation has corrected requires compliance with all requirements of the rule provided at the number and MN Rule number indicated. When a rule contains several items, fair comply with any of the items will be contacted for compliance. Lack of compliance re-inspection with any item of multi-part result in the assessment of a fine even that was violated during the initial inspectorrected.	n issued tion, it is s cited n violation ordance / rule of s been e tag I below. lure to esidered e upon rule will if the item			
	You may request a hearing on any asset that may result from non-compliance will orders provided that a written request is the Department within 15 days of receip notice of assessment for non-compliance.	ith these s made to ot of a			
	INITIAL COMMENTS: You have agreed to participate in the el receipt of State licensure orders consis the Minnesota Department of Health Informational Bulletin 14-01, available a http://www.health.state.mn.us/divs/fpcfobul.htm The State licensing orders delineated on the attached Minnesota	tent with at /profinfo/in			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

(X6) DATE 09/26/16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			
		00452	B. WING		09/	01/2016
	PROVIDER OR SUPPLIER	ONE MEDICAL C 109 COU	DRESS, CITY, S RT AVENUE S ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correct Minnesota Department he State Licensing federal software. Ta assigned to Minnesota Department he State Licensing federal software. Ta assigned to Minnesota Department he State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of c "Summary Statement and replaces the "Torrection order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Corplease DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. Jugh 9/1/2016, surveyors of this visited the above provider and tion orders are issued. Jught of Health is documenting Correction Orders using an umbers have been not a state statutes/rules for the prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis column also				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
7.1.12 . 2.11.	o. co20		A. BUILDING:			
		00452	B. WING		09/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH - SANDST	ONE MEDICAL C	RT AVENUE : ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	MINNESOTA STAT	E STATUTES/RULES.				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			9/26/16
		omprehensive plan of care personnel involved in the				
	by: Based on observation review the facility face services as directed ulcer interventions reviewed for pressure facility failed to ensincluded in activities directed by the care. Findings include: R8's Face Sheet dadiagnoses included following cerebrova affecting the right scomprehend and for dysfunction in speciaused by a cerebraterm anticoagulant buttocks and pain. The Skin Care Planhad a history of preright buttock. The care	ent is not met as evidenced on, interview and document ailed to provide care and d by the care plan for pressure for 1 of 3 residents R8 ure ulcers. In addition, the ure 1 of 2 residents (R27) was soutside of his room as e plan. ated 8/31/16, indicated R8's hemiplegia and hemiparesis iscular disease (stroke) ide, aphasia (inability to irmulate language because of ific brain regions. Most often al vascular accident), long use, pressure ulcer on the in dated 9/5/14, indicated R8 ssure ulcer on the left and and a current pressure ulcer on ire plan directed staff to its of side every hour to reduce		Corrected		

6899

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00452	B. WING		09/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FSSENT	IA HEALTH - SANDST	ONE MEDICAL C	RT AVENUE S			
LOOLITI		SANDSTO	ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	5 Continued From page 3		2 565			
	R8 was to be one of dining room and on the dining room due The undated nursi	ttocks due to skin breakdown. If the last residents in the e of the first residents out of to hourly repositioning. In assistant (NA) care guide reposition side to side or				
	On 8/31/16, R8 was continuously observed from 7:05 a.m. until 9:01 a.m. when R8 put on the call light on to lay down.					
	wheelchair dressed NA-C brought R8 to and placed him at t done eating and whroom and remained television until 9:01 light. NA-C entered they were going to got up in the wheele was when R8 usual breakfast. NA-C ve or offloaded every or returned to his roor	s observed up in the for the day. At 7:35 a.m. of the main dining room (MDR) he table. At 8:35 a.m. R8 was neeled himself back to his in the wheelchair watching a.m. when R8 put on the call the room and reassured R8 lay him down. NA-C stated R8 chair at about 7:30 and that lly went to the MDR for rified R8 was to repositioned one hour. NA-C was aware R8 in at 8:35 a.m. but she was still list. R8 was then transferred the mechanical lift.				
	DON verified R8 was offloaded every hou hourly repositioning MDR and first ones eating the NA shou offer repositioning. would expect staff the NAs were unab	a.m. the director of nursing as to be repositioned or ar. The residents who were should be the last ones in the cout. If the resident was still lid approach the resident and The DON further stated she to follow the care plan and if lie to get to the residents in sect the NAs to ask the nurses				

Minnesota Department of Health

STATE FORM BNUW11 If continuation sheet 4 of 29

Minnesota Department of Health

D WING	
00452 B. WING 09/01/2	/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
to reposition residents and the activity staff can also help transfer residents. The facility was unable to provide a policy on following the care plan. R27's Face Sheet printed 8/31/16, indicated diagnoses including hemiplegia following CVA, and major depression. R27's quarterly minimum data set (MDS), dated 6/16/16, indicated R27 R27's quarterly minimum data set (MDS), dated 6/16/16, indicated R27 R27's quarterly minimum data set (MDS), dated 6/16/16, indicated R27 R27's quarterly minimum data set (MDS), dated 6/16/16, indicated R27 had severely impaired cognition, but could be understood and usually understands. R27's MDS indicated inattention comes and goes, but there was no documentation of behaviors or rejection of cares. The MDS indicated R27 is totally dependent on staff for transfers, eating (gastronomy tube) and tolleting. The MDS indicated R27 required extensive assistance with personal hygiene and bed mobility. R27's Care Plan dated 6/15/16, indicated R27 usually made himself understood and understand information and indicated much prompting was needed to get R27 out of his room, and directed staff to bring R27 out of his room, and directed staff to bring R27 to this room, and directed staff to bring R27 to this room, and eliminate a day to watch and listen to peers and staff. The care plan also directed staff to bring R27 to whichever group activity was occurring when he was awake, that R27 was on a 1:1 program with activities staff and participates in the Sensory Stem program. Finally, the care plan indicated R27 liked to watch Gunsmoke daily at noon. Review of R27's group sheet directed staff to get R27 out of bed at least twice daily and bring to	

Minnesota Department of Health

STATE FORM BNUW11 If continuation sheet 5 of 29

PRINTED: 10/18/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 00452 09/01/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH **ESSENTIA HEALTH - SANDSTONE MEDICAL C** SANDSTONE, MN 55072 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 5 6 5 Continued From page 5 2 565 sheet indicated R27 like to people watch and is to be up in a wheelchair for every activity. The group sheet also directs staff that R27 participates in "stem group" at 6:00 on Tuesdays and Thursdays. Throughout the survey, during observations on 8/30/16 and 8/31/16. R27 was observed in his room and was not observed outside his room... Review of R27's activities participation revealed: -The last time R27 attended the care planned activity Sensory Stem was 6/24/16. During June, July and August of 2016, only 2 activity refusals were noted. On 8/31/16, at 1:47 p.m., Activity Director (AD)-A confirmed R27's care plan stated to assist him out of his room for all activities. AD-A stated numerous attempts had been made to get staff to follow R27's care plan, but verified staff are not following R27's activities care plan.

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SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could

The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are followed to avoid the development of pressure ulcers and to ensure residents participate in activities according to their care plan.

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.

Minnesota Department of Health STATE FORM

BNUW11 If continuation sheet 6 of 29

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			
		00452	B. WING		09/0	01/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
ESSENT	IA HEALTH - SANDST	ONE MEDICAL C	RT AVENUE : ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and e; General	2 830			9/23/16
	receive nursing cardicustodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to honor bathing frequency choices for 3 of 3 residents (R12, R4 and R25). Findings include:			Corrected		
	R12's Face Sheet, included, hemiplegi	indicated R12's diagnoses a, hemiparesis and language cerebral infarction (stroke), I disabilities.				
	7/13/16, indicated F had moderatively in also indicated he re	imum Data Set (MDS) dated R12 was hard of hearing and npaired cognition. R12's MDS equired one person to n with the activity of bathing.				
		ed 10/8/15 indicated R12 with activities of daily living				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING: CO			
		00452	B. WING		09/0	1/2016
	PROVIDER OR SUPPLIER	ONE MEDICAL C 109 COUR	ORESS, CITY, S RT AVENUE S DNE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	(ADL's) including be Parkinson's, CVA we R12's undated bath R12 preferred a batinformation on the formation on 8/31/16, at 11:4 stated R12 took two Tuesday and Sature On 8/31/16, FM-A con Tuesday and Sature on Tuesday and Sature on Tuesday and Sature on Monday, during formation on Monday, during for Monday, during formation on Monday, during for Monday, during formation on Monday, during f	athing, related to diagnoses of ith left sided hemiparesis. preference card indicated th. The preference card lacked requency of baths per week. 7 a.m. family member (FM)-A o showers a week at home, on day. confirmed that R12 had baths turday at home, but took just to the facility. cility's bath schedule for R12 was scheduled for a bath the day shift. a.m., nursing assistant (NA)-D in have only one bath during sident wants an extra bath it is the afternoon shift and they nedule. There are only 2 we their baths in the evening ir only bath of the week, not a extwo residents just prefer to NA-D stated the facility on Friday, Saturday and rear ago. ximately 9:32 a.m. Employee aide only works Monday o that is when baths are seed 2 residents want their gs, so those are done by not the bath aide. E-B said a more than one bath a week,	2 830			

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 BOILDING.			
		00452	B. WING		09/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH - SANDS	IONE MEDICAL C	RT AVENUE S ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 8	2 830			
	On 9/1/16, at 9:56 asked for more bat	a.m. (NA)-D stated R12 hasn't hs, but she does remember a bath on Monday and				
	diagnoses included pulmonary disease kyphosis, glaucoma The quarterly Minin 7/15/16, indicated I impairment, behavineeded the extensi	e Sheet indicated R4's d chronic obstructive , heart failure, depression, a and osteoporosis. num Data Set (MDS) dated R4 had no cognitive iors or rejection of cares. R4 ive assistance of one staff with ring and needed physical help rt of the bathing.				
	On 8/29/16, at 3:48 p.m. R4 stated she only got a bath once a week. R4 showered every day when at home. "I've always been over clean. I washed my hair every day, I have oily skin." R4 stated she would like a bath more than once a week and was not offer or informed she could have a bath more than once a week. R4 further stated the staff was so busy so she had never requested another bath.					
	Assessment dated important to choose preferred a tub batt	al History and Preferences 6/28/16, indicated it was very e type of bath and R4 h. The assessment lacked the number of baths in a week.				
	R4 preferred to tak liked to be assisted in the tub with the j Preference Card la number of baths in					
	The Bath Schedule	(undated) indicated R4 was				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILDING.			
		00452	B. WING		09/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ESSENT	IA HEALTH - SANDS	CONE MEDICAL C	RT AVENUE : ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 9	2 830			
	scheduled to receive morning.	ved her bath on Tuesday				
	stated R4 had not a the bath would hav	a.m. nursing assistant (NA)-D asked for an extra bath and e to be done on the afternoon stated, "R4 loves her bath."				
	stated she does res	a.m. registered nurse (RN)-A sident care conferences and red an another bath during the				
	diagnoses included	ce Sheet indicated R25's I muscular dystrophy, bursitis I ptosis (drooping of the upper eyelids.				
	indicated R25 had	nge MDS dated 6/15/16, no cognitive impairment. R25 sistance of two staff with				
	received a bath one bath twice a week. move in she received but then the schedumoved from evening received a bath one everyone received was not told why, the but this was what the she was not asked changed. R25 stated day at home. R25 fthe facility for 4 years	p.m. R25 stated she only ce a week and would prefer a R25 stated when she first ed a bath two times a week ule changed and her bath was ags to days and now she only ce a week. R25 stated their bath during the day. R25 he bath scheduled changed ney were doing. R25 stated or told why the schedule had ed she took a shower every further stated she has lived at ars and it had been a couple of been getting a bath one time a				

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09/01/2016

00452

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING ___

NAIVIL OI			STATE, ZIP CODE	
ESSENT	IA HEALTH - SANDSTONE MEDICAL C	RT AVENUE : ONE, MN 550		
(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) COMPLETE DATE
2 830	Continued From page 10 The Customary Routine/Preferences Assessment dated 6/15/16, indicated it was very important to choose the type of bath. The assessment lacked the preference of the number of baths in a week. The Bathing Preference Card (not dated) indicated R25 preferred to take a bath with the jets on. The Bathing Preference Card lacked the preference of the number of baths in a week. The Bath Schedule (not dated) indicated R25 was scheduled to received her bath on Thursday morning and her hair was washed on Sunday in the beauty shop. On 9/1/16, at 9:05 a.m. NA-D stated she schedules the residents bath day. When a new resident was admitted they were entered into the open slot. NA-D further stated residents can only have one bath on the day shift and if they want an extra bath they would have to have it on the afternoon shift. R25 does not want a bath on afternoons because she only wants NA-D to give the bath. R25 was very time consuming and took approximately one and a half hours to do so the management only allow NA-D give R25 one bath a week and wash R25's hair only on Sunday. On 9/1/16, at 11:45 a.m. the DON stated a resident can have another bath in a week. The DON said if a resident asked for an extra bath, the facility would accommodate the request. However, the DON did say the facility did not have a mechanism in place to ask residents about this preference; residents would have to initiate the request. A policy on preferences of bathing frequency was requested but not provided.	2 830		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY LETED
71140 1 12/114	or continuonon	BENTI IOMIONI NOMBEN.	A. BUILDING:		OCIVII	LLTLD
		00452	B. WING		09/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH - SANDST	CONE MEDICAL C	RT AVENUE S ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 11	2 830			
	The Director of Nur develop, review, an procedures to ensu- honored. The Director of Nur educate all appropri procedures. The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: rsing or designee could ad/or revise policies and ure resident preferences are rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing R CORRECTION: Twenty-one				
2 900	Subp. 3. Pressure comprehensive res of nursing services	5 Subp. 3 Rehab - Pressure sores. Based on the ident assessment, the director must coordinate the	2 900			9/26/16
	development of a na provides that: A. a resident who without pressure sores unle condition demonstrate authenticates, that B. a resident was received necessar promote healing, promote healing, promote from developments are sores from developments.	o enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	This MN Requirem by:	ent is not met as evidenced				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00452	B. WING		09/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
L ESSENTIA HEALTH - SANDSTONE MEDICAL C			RT AVENUE ONE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 12	2 900			
	review, the facility f repositioning accor- assessed needs to pressure ulcers for for pressure ulcers.	ion, interview and document ailed to provide timely ding to the resident's prevent the development of 1 of 3 residents (R8) reviewed		Corrected		
	Findings include:					
	Pressure ulcer Adv Stage 2 Pressure II loss with exposed of Partial-thickness lo dermis. The wound	njury: Partial-thickness skin dermis. ss of skin with exposed bed is viable, pink or red, o present as an intact or				
	diagnoses included following cerebroval affecting the right sometime comprehend and for dysfunction in spectaused by a cerebro kidney disease, dyswith swallowing), lopressure ulcer on the quarterly Minin 6/20/16, indicated Fokay. R8 was able location, staff name in a nursing home. or rejection of cares assistance of 2 staff toilet use and person R8 upper and lowe one side. R8 was frand always incontir	ated 8/31/16, indicated R8's I hemiplegia and hemiparesis iscular disease (stroke) ide, aphasia (inability to ormulate language because of ific brain regions. Most often al vascular accident), chronic sphasia (difficulty of discomforting term anticoagulant use, ne buttocks and pain. Inum Data Set (MDS) dated R8's long term memory was to recall the season, his room as and faces and knew he was R8 did not have any behaviors is. R8 required the extensive if with bed mobility, transfers, anal hygiene. R8 did not walk. In extremities were impaired on requently incontinent of urine then of bowel. R8 was at risk and had one unhealed stage				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING.			
		00452	B. WING		09/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FSSENT	IA HEALTH - SANDST	CONE MEDICAL C	RT AVENUE			
LOOLITI	ATTEACTIT OARDO	SANDSTO	ONE, MN 550)72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 13	2 900			
2 900	two pressure ulcer. pressure ulcer was any healed pressur relieving device in tand was on a turning. The significant chat (CAA) dated 12/21/ for pressure ulcers put him at risk which and required the ast occasionally incont previous CVA with history of pressure of the bed up when a right hand contrate and was on Couma medication), which bruising. R8 had a cushion in the reclin honeycomb cushio offloaded and report A Skin Assessment used to determine Tolerance Assessment.	The oldest date of the 4/25/16 and R8 did not have re ulcers. R8 had a pressure the bed and the wheelchairing and repositioning program. The oldest date of the 4/25/16 and R8 did not have re ulcers. R8 had a pressure the bed and the wheelchairing and repositioning program. The oldest and the wheelchairing and repositioning program. The oldest and the wheelchairing and repositioning program. The oldest and the wheelchairing that the included: limited mobility sistance of two staff, inent of bowel and bladder, right sided hemiplegia, a ulcers, R8 requested the head a sleeping for comfort and had cure. He had atrial fibrillation adin (a blood thinning put R8 at increased risk of ROHO (pressure reducing air) ner and a pressure reducing in in wheelchair. R8 was to be sitioned every two hours. It with a Braden Scale (a tool pressure ulcer risk) and Tissue that its supporting structures and its supporting structures.				
	to endure the effect	ts of pressure without adverse 6, indicated R8 was at risk for				
	pressure ulcers. Ri mobility, occasiona (stroke) which affect requested to sleep	sk factors included; limited I incontinence, a previous CVA cted his right side,R8 with the head of the bed history of pressure ulcers. R8				
		d (to relieve pressure to an of one minute) or				
	A Progress Note da right buttock had tw areas with a periwo	ated 8/30/16, indicated R8's wo small partial thickness bund (the tissue surrounding was purple in color and was				

Minnesota Department of Health

STATE FORM BNUW11 If continuation sheet 14 of 29

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION DENTIFICATION NUMBER. A. BUILDING: DO(01/20		
R WING		
00452 B. WING 09/01/20	016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ESSENTIA HEALTH - SANDSTONE MEDICAL C 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	(X5) OMPLETE DATE	
2 900 Continued From page 14 blanchable. The periwound measured 7 centimeters (cm) by 6 cm. Within the periwound were: 1) A T-shaped scabbed area on the lower right buttock which measured 1 cm by 1.5 cm. 2) On the upper right of the right buttock was a scabbed area which measured 0.5 cm by 0.5 cm. The current treatment order was to apply Skin Prep (a barrier wipe) and Calmoseptine (a barrier cream) every shift with hourly repositioning. A Skin Assessment Progress Note dated 8/31/16, indicated R8 had dry flaky skin throughout the right buttock under the Calmoseptine cream. R8 had two scab-like areas on the right buttock. Measurements were: 1) 1.5 cm by 0.5 cm. One side of the wound was slightly lifting up. 2) 2 cm by 1 cm. The surrounding periwound was blanchable and was purple in color. The progress note further indicated the areas were most likely a result of mixed etiology of IAD (incontinence associated damage) along with friction and shearing (friction and shear are mechanical forces contributing to pressure ulcer formation. The tissue injury resulting from these forces may look like a superficial skin injury.) R8 was to be repositioned and offloaded every hour. The Skin Care Plan dated 9/5/14, indicated R8 was at risk for skin impairments or breakdown due to having right sided hemiparesis and aphasia due to a past CVA. R8 requested the head of the bed be up 30 degrees. The Braden score indicated R8 was at moderate risk for pressure ulcers. R8 had a history of pressure ulcers. R8 had a history of pressure ulcers. R8 had a history of pressure ulcer on the left and right buttock and had a current pressure ulcer on the buttock. The care		

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STATE FORM BNUW11 If continuation sheet 15 of 29

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00452	B. WING		09/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	TIA HEALTH - SANDST	ONE MEDICAL C	RT AVENUE : ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	pressure reducing of the recliner. A hone bed. The care plan reposition side to si pressure on the buf R8 was to be one of dining room and on the dining room and on the dining room due. The undated nursing directed the NAs to offload every hour. On 8/31/16, R8 was 7:05 a.m. until 9:01 light on to lay down. At 7:05 a.m. R8 was the room was dark, the room with the mas observed up in the day. At 7:35 a.m. main dining room (Itable. Also present other residents. Mo 7:45 a.m. staff took a.m. R8 received his breakf medication from the done eating and whom and remained television until 9:01 light. NA-C entered they were going to NA-C stated R8 go 7:30 and that was well made to office the state of the st	cushion in the wheelchair and eycomb sheet at the foot of the further directed staff to de every hour to reduce stocks due to skin breakdown. If the last residents in the e of the first residents out of e to hourly repositioning. In gassistant (NA) care guide reposition side to side or a.m. when R8 put on the call of the wheelchair dressed for the wheelchair dressed for the wheelchair dressed for the wheelchair dressed for the dining room was 6-8 at of the tables were empty. At R8's breakfast order. At 7:55 as to five tables were empty. At R8's breakfast order. At 7:55 as beverages. At 8:15 a.m. R8 ast. At 8:25 a.m. R8 received a nurse. At 8:35 a.m. R8 was neeled himself back to his din the wheelchair watching a.m. when R8 put on the call the room and reassured R8	2 900			

Minnesota Department of Health

STATE FORM BNUW11 If continuation sheet 16 of 29

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
		00452		B. WING		09/0	01/2016
	PROVIDER OR SUPPLIER	ONE MEDICAL C	109 COUF	DRESS, CITY, S RT AVENUE S DNE, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 900	further stated she han every one hour reposition him also was then transferred mechanical lift. R8 cares. R8 was observable wheelchair for 1 houseing repositioned. At 9:10 a.m. R8's bothe interim director cleansed the area of the coccyx. The substance. The DO was Calmoseptine. purplish area were measured: 1)1.5 cm by 0.5 cm 2) 2 cm by 1 cm. The DON applied the Calmoseptine created or expositioned or residents who were be the last ones in the resident was stiapproach the residents NAs to ask the nurand the activity staff residents. On 8/31/16, at 1:10 (LPN)-B stated if the with meals, they work was the nurand the activity staff residents.	sisting at breakfast. It ad another resident repositioning and she because he was lated onto the bed with the was provided inconting and 36 minutes with the was as a minute with the was as a minute with the was grown of nursing (DON). The first the buttocks to the area was covered with stated the white stated t	who was had to had to he hoo. R8 he nence without he bon right side the awhite abstance hin a large should es out. If ald oning, unable to expect the idents fer cal nurse assisting ition the	2 900			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0452

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

109 COURT AVENUE SOUTH

	109 COLIF	DRESS, CITY, S	STATE, ZIP CODE	
ESSENTI	IA HEALTH - SANDSTONE MEDICAL C	NE, MN 550		
(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) COMPLETE DATE
2 900	Continued From page 17 On 8/31/16, at 1:15 p.m. NA-A stated there were times when R8 went over the one hour repositioning times. The NAs try to get to the every one hour repositioning residents in time but sometimes they were assisting with meals or busy with another resident. On 8/31/16, at 1:25 p.m. NA-B stated the only time they are unable to reposition or offload R8 every hour was during breakfast. They can ask the nurses if they are unable to get to the residents who require every one hour repositioning. The facility's Pressure Ulcer and Non-Surgical Wound Documentation policy revised 2/15, indicated residents were to be turned and repositioned per the Tissue Tolerance Assessment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop a pressure ulcer unless it is clinically unavoidable, and residents who do have pressure ulcers are receiving the proper care and services needed to promote healing, prevent infection and promote new pressure ulcers from developing. 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	DEFICIENCY)	

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00452	B. WING	·····	09/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH - SANDS1	CONE MEDICAL C	RT AVENUE ONE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	age 18	21426			
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			9/23/16
	maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Prever Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implements.	e provider must establish and hensive tuberculosis ogram according to the most is infection control guidelines and States Centers for Disease intion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). Include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines. Anne with this subdivision must the nursing home.				
	by: Based on interview facility failed to ens had a baseline sym	ent is not met as evidenced and document review, the cure 2 of 5 residents (R4, R8) aptom screening for a first and second step tion to the facility.		Corrected		
	Findings include:					
	Transmission of My Health-Care Setting	es for Preventing the ycobacterium Tuberculosis in gs, 2005, (MMWR) directed all eive a baseline tuberculosis				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00452	B. WING		09/0	1/2016
ESSENTIA HEALTH - SANDSTONE MEDICAL C 109 COU		ONE MEDICAL C 109 COUR	ORESS, CITY, S RT AVENUE S DNE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	within 3 months price must include an asset factors for TB, and R4 was admitted to medical record lack and second step Misser and second s	in 72 hours of admission or or to admission. The screening sessment of the resident's risk any current TB symptoms. the facility on 4/1/15. R4's red documentation of a first antoux upon admission. facility on 9/4/14. The medical mentation of TB symptom or step mantoux. o.m. the interim director of ried she was unable to find ried she	21426			

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.11.	o. co2011		A. BUILDING:				
		00452	B. WING		09/0	1/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ESSENT	IA HEALTH - SANDST	ONE MEDICAL C	RT AVENUE : ONE, MN 550				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21426	Continued From pa	ge 20	21426				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21435	MN Rule 4658.0900 Recreation Program	O Subp. 1 Activity and n; General	21435			9/23/16	
	home must provide recreation program based on each indistrengths, and need meet the physical, well-being of each comprehensive rescomprehensive pla 4658.0400 and 465 provided opportunit	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and .					
	by: Based on observati review, the facility f	ent is not met as evidenced on, interview and document ailed to ensure 1 of 2 residents to participate in activities to essible.		Corrected			
	Findings include:						
		orinted 8/31/16, indicated g hemiplegia following CVA, ion.					
	6/16/16, indicated F cognition. R 27 car understands. R27's	imum data set (MDS), dated R27 had severely impaired n be understood and usually MDS also indicated and goes, but there was no					

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AND BLAN OF CORRECTION TO TRENTIFICATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00452	B. WING		09/0	01/2016
	PROVIDER OR SUPPLIER	ONE MEDICAL C 109 COUP	DRESS, CITY, S RT AVENUE S DNE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	documentation of both MDS indicated staff for transfers, etoileting. The MDS extensive assistant bed mobility. R27's Care Plan da would answer simp could put together stime. The care plan makes himself undinformation. The car prompting was neeroom. The care plan out of his room sev listen to peers and directed staff to brin activity was occurring on a 1:1 program participates in the Sthe care plan direct Gunsmoke daily at Review of R27's gransparticipates in the Sthe activity room whisheet indicated R27 was to be up in a wind Thursdays. On 8/30/16, at 2:54 recliner in his room on the TV in his room on the TV in his room on 8/30/16, at 4:48	ehaviors or rejection of cares. R27 is totally dependent on eating (gastronomy tube) and indicated R27 required be with personal hygiene and steed 6/15/16, specified R27 le yes or no questions and short sentences when given also indicated R27 usually erstood and understand re plan also indicated much ded to get R27 out of his in directed staff to bring R27 eral times a day to watch and staff. The care plan also ing R27 to whichever grouping when he was awake; R27 with activities staff; and R27 sensory Stem program. Finally, ed R27 liked to watch noon. Dup sheet directed staff to get east twice daily and bring to nile out of bed. The group related in the liked to people watch and heelchair for every activity. So directed staff R27 in group" at 6:00 on Tuesdays p.m. R27 was observed in the asleep. A Western show was	21435			
		its were going into the dining				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00452	B. WING		09/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ESSENT	IA HEALTH - SANDST	CONE MEDICAL C	RT AVENUE S ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Continued From pa	age 22	21435			
	room in preparatior	n for supper.				
	On 8/30/16, R27 wasleep with the TV	as observed in bed in his room on.				
	On 8/31/16, at 7:07 a.m. R27 was observed in bed with the TV on. The window curtain was closed and the lights were off.					
	On 8/31/16, at 8:47 awake in bed, with	a.m. R27 was observed the TV on.				
	variety of activities -residents were in t independent activiti newspaper, colorin -residents were sitt waiting for their turn were coming and g	ing outside the nurses station at the beauty shop and staff				
	entered R27's room and reposition R27 waiting for someon would check him and donned gloves, gat supplies to check a engage R27 in con until 9:18 a.m. whe forgot about me an assistance. NA-B ro a.m., at which time repositioned R27 in	a.m. nursing assistant (NA)-B in order to check, change. NA-B told R27 that she was e to help her and then they and reposition him. NA-B thered supplies and set up the and change R27. NA-B did not versation but stood, waiting in NA-B stated, they probably d left the room to find eturned with NA-A at 9:20 they checked, changed and in bed. After performing cares,				
	the lights, left the T no time did either N	shed their hands, turned out V on and left R27's room. At IA-B nor NA-A offer to get R27 his room. NA-B and NA-A did				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00452	2	B. WING		09/0	1/2016
NAME OF PROVIDER OR SUPPLIER ESSENTIA HEALTH - SANDSTONE MEDIC	DRESS, CITY, S RT AVENUE S DNE, MN 550				
(X4) ID SUMMARY STATEMENT OF D PREFIX (EACH DEFICIENCY MUST BE PRI TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435 Continued From page 23 not engage R27 in conversation of checking, changing and representation of changing and re	vas asked if he R27's eyes got big "no." When asked room more often, 'yes." sed practical nurse 27 remained in a.m. to give ube. vas observed in ghts off, window stated staff will get afternoon shift will ted those are the asked if he gets do he nodded his would like to get is head, "yes." cipation revealed e care planned 4/16. During June, 2 activity refusals was listed as TV was listed as visiting	21435			

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00452	B. WING		09/0	1/2016
ESSENTIA HEALTH - SANDSTONE MEDICAL C 109 COUL			DDRESS, CITY, STATE, ZIP CODE JRT AVENUE SOUTH TONE, MN 55072			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	In July of 2016, R275 days in July who listed as TV11 days in July who listed as rest, nappiA 5 day stretch frowhere he only resteroom10 days with famil10 days of facility In August of 2016, I11 days in August listed as TV3 days in August v listed as "rest" or "r13 days with famil7 days of facility in On 8/31/16, at 1:47 confirmed R27's calout of his room for a has had several colleft a note remindin for Stem group, to he doesn't happen. AD R27 refuses to comhis family has indical (don't ask yes or not he's out and get mo activities does a lot R27, and most of the Activities staff will see him awake in bester to start the staff will see him awake in bester to start the staff will see him awake in bester to start the staff will see him awake in bester to	r had: ere R27's only activity was ere R27's only activities were ng or sleep om 7/3/16 through 7/8/16 ed, slept or watched TV in his ey or friends visiting activity involvement R27 had: where his only activity was esting". y or friends visiting activity birector (AD)-A re plan states to assist him all activities. AD-A stated she enversations with nursing and g them to also get R27 ready have him up for games, but it b-A stated nursing indicated are out but if approached, as ated, as let's just go do this b), R27 will enjoy himself once ore socialization. AD-A stated of one on one activities with hem don't get charted. top and chat with R27 if they	21435			
	stated nursing and	p.m. registered nurse (RIN)-A activities are to offer activities of re-approach is a lot of it, and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00452	B. WING		09/0	1/2016
ESSENTIA HEALTH - SANDSTONE MEDICAL C 109 COUF			ORESS, CITY, S RT AVENUE S DNE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	once staff are able room, R27 enjoyed RN-A assumed staff opportunity to get on Therapeutic Activities 6/2014, indicated reference and gives participate in all activities. Program approach and physical addition, this policy do no meaningful an approach and offer or acceptance is to acceptance and/or in the care plan. SUGGESTED MET The Activity Director review, and/or revisensure resident's haprogram that meets the Activity Directorall appropriate staff procedures. The Activity Director monitoring systems compliance.	ge him to get up. RN-A stated to get him up and out of his people watching and music. If were offering R27 an ut of his room. See Program policy dated esidents of the facility shall be ven equal opportunities to ivities of program. Colicy, dated 6/2014, indicated ormed of when grouping and are encouraged to be sal assistance is provided. In indicted if resident appears to ctivity per their choice, staff activities. Resident's refusal be documented. Patterns of refusals are to be documented. THOD OF CORRECTION: or or designee could develop, e policies and procedures to ave an indivdualized activity their needs. Their or designee could educate on the policies and	21435			
21565	MN Rule 4658.1325 Medications Self Ac	5 Subp. 4 Administration of Imin	21565			9/23/16

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PRINTED: 10/18/2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ___ 00452 09/01/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **109 COURT AVENUE SOUTH ESSENTIA HEALTH - SANDSTONE MEDICAL C**

ESSENT	IA HEALTH - SANDSTONE MEDICAL C SANDSTO	NE, MN 55	072	
(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) COMPLETE DATE
21565	Continued From page 26	21565		
21565	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 safe self-administration of medications (SAM) for 1 of 3 residents (R12) observed for self-administration of a nebulizer treatment. Findings include: R12's Hospital Discharge Summary dated 8/24/16, included discharge diagnoses of pneumonia, nausea and vomiting, dysphagia (difficulty or discomfort with swallowing) and failure to thrive. The quarterly Minimum Data Set dated 7/25/16, indicated R12 was unable to complete the Brief Interview for Mental Status (BIMS). The Staff Assessment for Mental Status indicated R12's short and long term memory was okay. R12 had moderately impaired decision making skills. R12 did not have any behaviors or rejection of cares. R12 needed the extensive assistance of one staff with activities of daily living (ADL). A Communication/Information Fax Sheet dated	21565	Corrected	
	8/25/16, the physician ordered albuterol 2.5 milligrams (mg)/3 milliliters (ml) nebulizer (an inhaled medication that relaxes muscles in the airways and increases air flow to the lungs) four times a day for 10 days. The order and the			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		00452	B. WING		09/01/2016		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ESSENT	IA HEALTH - SANDST	ONE MEDICAL C	RT AVENUE : ONE, MN 550				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
21565	medical record lack nebulizer treatment On 8/29/16, at 1:30 in his room in the ware the nebulizer was a R12 appeared to be nurse (LPN)-B was nursing desk and the hall. LPN-B did 1:41 p.m. when she turned off the nebuli other staff in the hall of the nebuli other in the interim director R12's room across the hall of the nebuli other walked the nebuli of the medication cart at the neducation cart at	p.m. R12 was observed alone theelchair with his head down. Tunning via face mask and a sleeping. Licensed Practical at medication cart at the nen walked to the other end of not return to R12's room until a removed the face mask and lizer machine. There were no ll or near R12's room. 8 a.m. R12 was observed a the wheelchair with his head ar was running via face mask to be sleeping. LPN-B was at the nursing desk. At 10:11 a.m. of nursing (DON) walked past and of the hall and back. At brought medications to the all from R12. At 10:23 a.m. from across the hall but did not the nebulizer treatment. LPN-B dication cart at the desk. At walked past R12's room, nued to the end of the hall and ast R12's room to the he desk. At 10:27 a.m. LPN-B in. LPN-B stated, "it looks like"	21565				

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PRINTED: 10/18/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00452 09/01/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH **ESSENTIA HEALTH - SANDSTONE MEDICAL C** SANDSTONE, MN 55072 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21565 Continued From page 28 21565 On 8/30/16 at 4:10 p.m. the DON stated she saw R12 had the nebulizer on this morning and observed he was doing fine with leaving the face mask. The DON stated the nebulizer was new for him so they got the order and he was assessed for SAM today. The DON would expect staff to stay with the resident until they were assessed to SAM the nebulizer. R12 had just returned from the hospital on 8/24/16. The DON further stated if a resident was okay to SAM it would be written on the medication administration record (MAR) and included in the care plan. The facility's Self-Administration of Medications policy dated 8/28/15, indicated the purpose was to assist the resident to take their medications in a safe manner and educate the resident regarding their medications. This included: the name of the drug, the dosage, time and method of administration and any possible side effects. The interdisciplinary team (IDT) would determine if it was safe for a resident to SAM and a physician's order would be obtained. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not self administer medications until assessed safe to do The Director of Nursing or designee could

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procedures.

compliance.

(21) days.

educate all appropriate staff on the policies and

TIME PERIOD FOR CORRECTION: Twenty-one

The Director of Nursing or designee could develop monitoring systems to ensure ongoing

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