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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BNUW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00452

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2013**
6. DATE OF SURVEY **10/31/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Theresa Ament, Unit Supervisor 11/21/2016
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/16/2016
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/07/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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 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

MDH
Minnesota Department of Health

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245454 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE 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	09/26/2016	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	11/04/2016	29433	10/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (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

ID: BNUW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00452

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/01/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR SWS 0926/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/18/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	09/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This 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.	F 176	F-176 (D) Resident self-administer drugs if deemed safe: Element #1: Resident #R12 was reviewed for appropriateness of SAM & SAM assessment was completed on 8/30/2016, along with MD order for resident to SAM. Resident # R12 was again re-assessed for appropriateness on 9/8/16 after returning from hospitalization & was found appropriate to SAM nebulizer after set-up by nursing with checks for compliance & completion of medication.	9/23/16

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

Electronically Signed | 09/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	09/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 1 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 8/25/16, the physician ordered albuterol 2.5 milligrams (mg)/3 mililiters (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 medical record lacked an order to SAM the nebulizer treatment. On 8/29/16, at 1:30 p.m. R12 was observed alone in his room in the wheelchair with his head down. The nebulizer was running via face mask and R12 appeared to be sleeping. Licensed Practical nurse (LPN)-B was at medication cart at the nursing desk and then walked to the other end of the hall. LPN-B did not return to R12's room until 1:41 p.m. when she removed the face mask and turned off the nebulizer machine. There were no other staff in the hall or near R12's room. On 8/30/16, at 10:08 a.m. R12 was observed again in his room in the wheelchair with his head down. The nebulizer was running via face mask and R12 appeared to be sleeping. LPN-B was at medication cart at the nursing desk. At 10:11 a.m. the interim director of nursing (DON) walked past R12's room to the end of the hall and back. At 10:17 a.m. LPN-B brought medications to the	F 176	Element #2: All other residents that had potential to be affected by this deficient practice have been reassessed for appropriateness. Element #3: To prevent this from happening again, education was provided to the nurses on duty on 8/30/2016 and passed through report. The admission/re-admission resident checklist was updated to address if a resident needs to have a SAM completed upon admit/re-admit. Nursing staff were reminded of the SAM policy via weekly Friday news publication on 9/2/2016 & 9/9/2016. Nursing staff were educated on 9/19/16 at mandatory meeting of importance of making sure a SAM was obtained for residents & if resident does not have a SAM they may not leave resident alone with medication. The facility Sam policy was reviewed. Element #4: To maintain compliance with Self-Administration of medication the Resident Care Coordinator or designee will review all residents with a current SAM each month x 3 months, then as need based upon findings. Resident Care Coordinator or designee will review all admits/re-admits to see if there is a need for a SAM & appropriateness of each resident to SAM. Nursing Staff will be reminded of SAM policy monthly x 3 months via Friday notes publication. Negative findings will be reported to the DON & at the quarterly quality meetings.	

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	245454	A. BUILDING _____ B. WING _____	09/01/2016

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F 176	Continued From page 2 room across the hall from R12. At 10:23 a.m. LPN-B exited the room across the hall but did not check on R12 and the nebulizer treatment. LPN-B returned to the medication cart at the desk. At 10:26 a.m. LPN-B walked past R12's room, looked in and continued to the end of the hall and then walked back past R12's room to the medication cart at the desk. At 10:27 a.m. LPN-B entered R12's room. LPN-B stated, "it looks like you're done" and closed the door. On 8/30/16, at 2:30 p.m. LPN-B, verified she left R12 alone with the nebulizer treatment running. LPN-B stated she usually set up the nebulizer treatment, leaves him alone in his room and returns and removes the nebulizer treatment when it was done. 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	F 176	Element #5: The facility will be in full compliance with F-176 by 9/23/2016	

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F 176	Continued From page 3 if it was safe for a resident to SAM and a physician's order would be obtained.	F 176		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to honor bathing frequency choices for 3 of 3 residents (R12, R4 and R25). Findings include: R12's Face Sheet, indicated R12's diagnoses included, hemiplegia, hemiparesis and language deficits following a cerebral infarction (stroke), and mild intellectual disabilities. R12's quarterly Minimum Data Set (MDS) dated 7/13/16, indicated R12 was hard of hearing and had moderatively impaired cognition. R12's MDS also indicated he required one person to physically assist him with the activity of bathing. R12's care plan dated 10/8/15 indicated R12 required assistance with activities of daily living (ADL's) including bathing, related to diagnoses of Parkinson's, CVA with left sided hemiparesis.	F 242	F-242 (D) Self-determination □ Right to Make Choices: Element #1: Resident # R12, R4, R25 were added to the bath schedule for twice weekly baths Element #2: All other residents that had potential to be affected by this deficient practice have been re-assessed for preference of how many baths they would prefer in a week based on interview with resident or family. Element #3: To prevent this from happening again, the Activities/Social History form was updated to ask how many baths per week was preferred by resident, Program Director of Activities or designee will update Resident Care Coordinator or designee on resident□s preference. This form is completed on	9/23/16

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F 242	Continued From page 4 R12's undated bath preference card indicated R12 preferred a bath. The preference card lacked information on the frequency of baths per week. On 8/30/16, at 11:47 a.m. family member (FM)-A stated R12 took two showers a week at home, on Tuesday and Saturday. On 8/31/16, FM-A confirmed that R12 had baths on Tuesday and Saturday at home, but took just one since moving to the facility. In a review of the facility's bath schedule for 8/29/16, to 9/1/16, R12 was scheduled for a bath on Monday, during the day shift. On 9/1/16, at 9:04 a.m., nursing assistant (NA)-D stated residents can have only one bath during the day shift. If a resident wants an extra bath it is the responsibility of the afternoon shift and they have a different schedule. There are only 2 residents that receive their baths in the evening now, and that is their only bath of the week, not a second bath. Those two residents just prefer to bath in the evening. NA-D stated the facility discontinued baths on Friday, Saturday and Sunday close to a year ago. On 9/1/16, at approximately 9:32 a.m. Employee (E)-B said the bath aide only works Monday through Thursday so that is when baths are scheduled. E-B stated 2 residents want their baths in the evenings, so those are done by nursing assistants, not the bath aide. E-B said they used to provide more than one bath a week, until about a year ago. On 9/1/16, at 9:56 a.m. (NA)-D stated R12 hasn't asked for more baths, but she does remember	F 242	admission, quarterly, annually & with significant changes. Staffing schedule has been changed to meet the needs of the resident□s preferences for bathing. The bathing preference card for each resident has been updated to include their preferred number of baths/shower a week. Element #4: To maintain compliance with resident bathing preferences, DON or designee will interview 2 - 3 residents□ weekly x 1 month, then 5 - 6 residents monthly x 2 months. Resident Care Coordinator or designee will follow-up with resident or family member at care conferences to make sure resident preference is being followed. Negative findings will be reported to DON & at quarterly quality meetings. Element #5: The facility will be in full compliance with F-242 by 9/23/2016	

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F 242	Continued From page 5 R12 saying he took a bath on Monday and Saturday when living at home. On 9/1/16, at 11:47 a.m. the director of nursing (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. R4's Resident Face Sheet indicated R4's diagnoses included chronic obstructive pulmonary disease, heart failure, depression, kyphosis, glaucoma and osteoporosis. The quarterly Minimum Data Set (MDS) dated 7/15/16, indicated R4 had no cognitive impairment, behaviors or rejection of cares. R4 needed the extensive assistance of one staff with activities of daily living and needed physical help of one staff with part 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. The Activities Social History and Preferences Assessment dated 6/28/16, indicated it was very important to choose type of bath and R4 preferred a tub bath. The assessment lacked the	F 242		

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F 242	Continued From page 6	F 242		

preference of the number of baths in a week.

The Bathing Preference Card (undated) indicated R4 preferred to take a bath with the jets on and liked to be assisted with bathing while she relaxed in the tub with the jets on. The Bathing Preference Card lacked the preference of the number of baths in a week.

The Bath Schedule (undated) indicated R4 was scheduled to received her bath on Tuesday morning.

On 9/1/16, at 9:10 a.m. nursing assistant (NA)-D stated R4 had not asked for an extra bath and the bath would have to be done on the afternoon shift. NA-D further stated, "R4 loves her bath."

On 9/1/16, at 11:45 a.m. registered nurse (RN)-A stated she does resident care conferences and R4 had not requested an another bath during the week.

R25's Resident Face Sheet indicated R25's diagnoses included muscular dystrophy, bursitis of the shoulder and ptosis (drooping of the upper eyelid) of bilateral eyelids.

The significant change MDS dated 6/15/16, indicated R25 had no cognitive impairment. R25 needed the total assistance of two staff with bathing.

On 8/29/16, at 4:10 p.m. R25 stated she only received a bath once a week and would prefer a bath twice a week. R25 stated when she first move in she received a bath two times a week but then the schedule changed and her bath was moved from evenings to days and now she only

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F 242	Continued From page 7	F 242		

received a bath once a week. R25 stated everyone received their bath during the day. R25 was not told why, the bath scheduled changed but this was what they were doing. R25 stated she was not asked or told why the schedule had changed. R25 stated she took a shower every day at home. R25 further stated she has lived at the facility for 4 years and it had been a couple of years that she had been getting a bath one time a week.

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.

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F 242	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.	F 242		
F 248 SS=D	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. R27's Care Plan dated 6/15/16, specified R27	F 248	F-248(D) Activities meets interests/needs of each resident: Element # 1: Activity Director reviewed resident # 27 attendance record. It was passed off in report the importance of getting resident # 27 out of bed and to Activities. Element # 2: All other residents that had potential to be affected by this deficient practice have been reassessed for appropriateness. Element # 3: To prevent this from happening again Activity staff were educated by Activity Director on 9/7/2016 and all staff was educated on 9/19/2016 at the all staff neighborhood meeting. NAR□S will have resident # 27 up for all groups, NAR sheets were updated for each resident that participates in Sensory Stem group and 1:1□s. Sensory Stem, 1:1 flow sheets and attendance sheets	9/23/16

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F 248	Continued From page 9 would answer simple yes or no questions and could put together short sentences when given time. The care plan also indicated R27 usually makes himself understood and understand information. The care plan also indicated much prompting was needed to get R27 out of his room. The care plan directed staff to bring R27 out of his room several times 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; R27 is on a 1:1 program with activities staff; and R27 participates in the Sensory Stem program. Finally, the care plan directed 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 the activity room while out of bed. The group sheet indicated R27 liked to people watch and was to be up in a wheelchair for every activity. The group sheet also directed staff R27 participates in "stem group" at 6:00 on Tuesdays and Thursdays. On 8/30/16, at 2:54 p.m. R27 was observed in the recliner in his room, asleep. A Western show was on the TV in his room. On 8/30/16, at 4:48 p.m. R27 was observed in bed in his room, asleep. The TV was on in his room, other residents were going into the dining room in preparation for supper. On 8/30/16, R27 was observed in bed in his room asleep with the TV on. On 8/31/16, at 7:07 a.m. R27 was observed in bed with the TV on. The window curtain was	F 248	were updated and implemented. Staff was updated of the Sensory Stimulation group days and times and what to do if resident refuses group via Friday notes publication on 9/9/16. Element # 4: To maintain compliance for activities to meet the interests and needs of each resident the Activities Director or Designee will audit 3 residents weekly for 1 month, 2 residents weekly for 2 months and as needed for 3 months. Activities Director/Designee will follow up at care conferences with resident or family member to ensure resident is attending activities of interest and discuss attendance. Activity Director will make adjustments as needed in residents activity planning. Policies were reviewed and updated by staff on 9/20/2016. Element # 5: The facility will be in full compliance with F-248 by 9/23/2016.	

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F 248	Continued From page 10 closed and the lights were off. On 8/31/16, at 8:47 a.m. R27 was observed awake in bed, with the TV on. From 8/31/16 at 8:51 a.m. until 9:08 a.m. a variety of activities were occurring in the facility: -residents were in the activity room doing independent activities (cards, reading the newspaper, coloring) -residents were sitting outside the nurses station waiting for their turn at the beauty shop and staff were coming and going. -3 residents were in the bird room waiting for an activity to begin. On 8/31/16, at 9:08 a.m. nursing assistant (NA)-B entered R27's room in order to check, change and reposition R27. NA-B told R27 that she was waiting for someone to help her and then they would check him and reposition him. NA-B donned gloves, gathered supplies and set up the supplies to check and change R27. NA-B did not engage R27 in conversation but stood, waiting until 9:18 a.m. when NA-B stated, they probably forgot about me and left the room to find assistance. NA-B returned with NA-A at 9:20 a.m., at which time they checked, changed and repositioned R27 in bed. After performing cares, NA-A and NA-B washed their hands, turned out the lights, left the TV on and left R27's room. At no time did either NA-B nor NA-A offer to get R27 out of bed or out of his room. NA-B and NA-A did not engage R27 in conversation beyond the task of checking, changing and repositioning. On 8/31/16, at 9:28 a.m. R27 was asked if he gets out of his room enough. R27's eyes got big and he quickly shook his head "no." When asked	F 248		

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F 248	Continued From page 11 if he would like to get out of his room more often, R27 quickly nodded his head, "yes." On 8/31/16, at 11:03 a.m. licensed practical nurse (LPN)-B exited R27's room. R27 remained in bed. LPN-B returned at 11:09 a.m. to give medications in R27's feeding tube. On 8/31/16, at 1:05 p.m. R27 was observed in bed and the room was dark (lights off, window curtain pulled closed). On 8/31/16, at 1:06 p.m. NA-B stated staff will get R27 into his recliner now and afternoon shift will get him up once too. NA-B stated those are the best time for R27. On 8/31/16, at 1:46 p.m., when asked if he gets bored, R27's eyes widened and he nodded his head, "yes." When asked if he would like to get out more, R27 again nodded his head, "yes." 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. During June of 2016, R27 had: -4 days where his only activity was listed as TV -6 days where his only activity was listed as resting, napping or sleeping. -10 days with family or friends visiting --10 days of facility activity involvement (one-on-ones, music, etc.) In July of 2016, R27 had: --5 days in July where R27's only activity was listed as TV	F 248		

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F 248	Continued From page 12 --11 days in July where R27's only activities were listed as rest, napping or sleep --A 5 day stretch from 7/3/16 through 7/8/16 where he only rested, slept or watched TV in his room. --10 days with family or friends visiting --10 days of facility activity involvement In August of 2016, R27 had: --11 days in August where his only activity was listed as TV --3 days in August where his only activity was listed as "rest" or "resting". --13 days with family or friends visiting --7 days of facility involvement. On 8/31/16, at 1:47 p.m. Activity Director (AD)-A confirmed R27's care plan states to assist him out of his room for all activities. AD-A stated she has had several conversations with nursing and left a note reminding them to also get R27 ready for Stem group, to have him up for games, but it doesn't happen. AD-A stated nursing indicated R27 refuses to come out but if approached, as his family has indicated, as let's just go do this (don't ask yes or no), R27 will enjoy himself once he's out and get more socialization. AD-A stated activities does a lot of one on one activities with R27, and most of them don't get charted. Activities staff will stop and chat with R27 if they see him awake in bed. On 8/31/16, at 1:54 p.m. registered nurse (RN)-A stated nursing and activities are to offer activities to R27. RN-A stated re-approach is a lot of it, and staff are to encourage him to get up. RN-A stated once staff are able to get him up and out of his room, R27 enjoyed people watching and music. RN-A assumed staff were offering R27 an	F 248		

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	245454	A. BUILDING _____ B. WING _____	09/01/2016

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F 248	Continued From page 13 opportunity to get out of his room. Therapeutic Activities Program policy dated 6/2014, indicated residents of the facility shall be encouraged and given equal opportunities to participate in all activities of program. Activities Program policy, dated 6/2014, indicated that resident are informed of when group activities are occurring and are encouraged to be involved and physical assistance is provided. In addition, this policy indicted if resident appears to do no meaningful activity per their choice, staff approach and offer activities. Resident's refusal or acceptance is to be documented. Patterns of acceptance and/or refusals are to be documented in the care plan.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		9/26/16

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F 278	Continued From page 14 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 residents (R5) reviewed for MDS accuracy for Activities of Daily Living (ADLs). Findings include: On 08/31/2016, at 7:46 a.m. R5 was observed walking down the hallway towards the dining room. A nursing assistant was holding R5's gait belt with a nurse walking slowly behind R5 with a wheelchair. R5 walked approximately 25 feet, expressed she was tired, sat down in the wheelchair at which time she was pushed by the aide into the dining room. R5 had diagnoses which included dementia, gait and mobility abnormalities, and neuropathy as indicated on the Resident Face Sheet dated 9/1/16. The Annual MDS dated 4/21/16, indicated R5 required limited assistance for locomotion on the unit, however the Quarterly MDS dated 7/21/16, indicated R5 required extensive assistance. In addition, the Annual MDS dated 4/21/16, indicated R5 required only supervision	F 278	F 278 (D) Assessment Accuracy/Coordination/Certified: Element #1: Resident #5 Annual MDS dated 4/21/16 and MDS dated 7/21/16 were modified to accurately reflect locomotion on the unit. Element #2: For other residents who may be affected by this practice a review of admission, and/or quarterly assessments will be completed to ensure ADL functional status is accurate. Upon completion of the review any concerns will be forwarded to the IDT Team for follow up. Element #3: The policy for MDS coding was implemented by the interdisciplinary team on (09/23/16). The Interdisciplinary members were trained as it relates to their respective roles and responsibilities regarding the audit tools and the MDS policy and procedures on (09/23/2016). Element #4: 4 Random MDS ADL audits	

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F 278	Continued From page 15 for locomotion off the unit, however the Quarterly MDS dated 7/21/16, indicated R5 required extensive assistance. On 9/1/16, at 2:30 p.m. the Interim Director of Nursing (DON) provided a 7-Day Point of Care Answers data collection tool used to code the 4/21/16 and 7/21/16 MDS's, stating they collect this data prior to coding any MDS. The data collection tool indicated R5 was extensive assistance for both locomotion on and off the unit from 4/15/16 to 4/21/16 and from 7/15/16 to 7/21/16. During interview on 9/1/16, at 1:31 p.m. the DON stated a consultant MDS nurse completed both the 4/21/16 and 7/21/16 MDS's. DON verified that based on the data collected, R5 should have been coded extensive assist for both locomotion on and off the unit in April and that July was coded correctly. DON verified the MDS staff coded the 4/21/16 Annual MDS incorrectly. DON verified there was no MDS coding policy.	F 278	on scheduled assessments will be completed prior to transmission monthly for 3 months, and then quarterly for 1 year to ensure compliance with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. Negative findings will be reported to DON or designee. Element # 5: The facility will be in full compliance with F-278 by 9/26/2016	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care and services as directed by the care plan for pressure ulcer interventions for 1 of 3 residents R8	F 282	F-282 (D) Services by qualified persons/per care plan: Element #1: Staff on duty was notified of	9/26/16

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F 282	Continued From page 16 reviewed for pressure ulcers. In addition, the facility failed to ensure 1 of 2 residents (R27) was included in activities outside of his room as directed by the care plan. Findings include: 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	F 282	importance of following plan of care for resident #R8 by offloading/repositioning as directed by POC & asking for assistance when needed. Staff on duty was notified of importance of following plan of care for resident #R27 of getting him out of bed & to activities. Element #2: All other residents that had potential to be affected by this deficient practice have been reassessed for appropriateness. Element #3: To prevent this from happening again, education was provided to staff on duty on 8/31/16 & passed through report. Staff was also reminded of importance on 9/2/16, 9/9/16 and 9/23/16 via weekly Friday news publications. 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 Planning was reviewed & updated. Element #4: To maintain compliance with Services by qualified persons/per care plan the Resident Care Coordinator & Activity Director (or their designee) will review 5 residents plan of care, of their department, each month x 3 months then as need based upon findings. Resident Care Coordinator or designee will perform 5 audits of nursing staff with following plan of care each month x 3 month then as need based upon findings. Activity Director or designee will perform 5 audits of activity staff with following plan of care	

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F 282	Continued From page 17 room and remained in the wheelchair watching television until 9:01 a.m. when R8 put on the call light. NA-C entered the room and reassured R8 they were going to lay him down. NA-C stated R8 got up in the wheelchair at about 7:30 and that was when R8 usually went to the MDR for breakfast. NA-C verified R8 was to repositioned or offloaded every one hour. NA-C was aware R8 returned to his room at 8:35 a.m. but she was still assisting at breakfast. R8 was then transferred onto the bed with the mechanical lift. On 8/31/16, at 9:45 a.m. the director of nursing DON verified R8 was to be repositioned or offloaded every hour. The residents who were hourly repositioning should be the last ones in the MDR and first ones out. If the resident was still eating the NA should approach the resident and offer repositioning. The DON further stated she would expect staff to follow the care plan and if the NAs were unable to get to the residents in time she would expect the NAs to ask the nurses 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. Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R27) was included in activities outside of his room according to his care plan. Findings include: R27's Face Sheet printed 8/31/16, indicated diagnoses including hemiplegia following CVA, and major depression.	F 282	each month x 3 months then as need based upon findings. Negative findings will be reported to the DON & reported at quarterly quality meetings. Element #5: The facility will be in full compliance with F282 by 9/26/2016	

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F 282	Continued From page 18	F 282		

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 toileting. 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 several times 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 the activity room while out of bed. The group 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..

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F 282	Continued From page 19 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.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to coordinate care between the hospice provider and the facility for 1 of 1 residents (R30), reviewed for hospice. Findings include: R30's face sheet printed 9/1/16, indicated diagnoses that included malignant neoplasm of upper-outer quadrant of right breast, secondary malignant neoplasm of brain, secondary malignant neoplasm of liver and intrapatic bile	F 309	F-309 (D) Provide care/services for highest well being: Element #1: Resident Care Coordinator spoke with RN Case Manager for Resident #R30 to coordinate care. Element #2: Resident Care Coordinator has coordinated care for all other residents that had potential to be affected by this deficient practice.	9/23/16

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F 309	Continued From page 20 duct, and encounter for palliative care. According to R30's Hospice Care Plan, dated 3/30/16, R30 signed on to hospice on 2/21/16. R30's quarterly Minimum Data Set (MDS) dated 7/7/16, indicated R30 had a prognosis that may mean a life expectancy of less than 6 months. The MDS also indicated R30 suffered from depression. R30's Care Plan, dated 3/30/16, indicated hospice for end of life care beginning on 2/21/16, for a diagnosis of metastatic breast cancer. Interventions included to coordinate care with the facility, registered nurse and care coordinator, and for the hospice aide to provide additional care needs weekly above the cares the facility staff was already providing. Review of the nursing assistant group sheet for R30 states "hospice" in red capital letters, but lacked direction on when hospice came to the facility. On 8/30/16, at 4:59 p.m. registered nurse (RN)-B stated she doesn't know when hospice is coming, they just show up. RN-B stated R30's hospice nurse "pops in" a few times a week, but she doesn't really know when they're coming. On 8/31/16, at 10:00 a.m. nursing assistant (NA)-A stated she doesn't know when the hospice aides are coming or what they'll be doing. She stated what they do differs from day to day. On 8/31/16, at 10:04 a.m. NA-B stated she doesn't know when the hospice aides are coming or what they'll be doing. NA-B stated she does her cares the same because she doesn't know	F 309	Element #3: To prevent this from happening again, Resident Care Coordinator or designee will speak with hospice residents RN Case Manager for hospice schedule Q monthly and calendar of schedule will be placed in staff report room for all staff to see. Resident Care Coordinator has spoken to hospice RN Case Manager about updating her with any changes to the schedule. Hospice policy was implemented. Element #4: To maintain compliance with provide care/services for highest well-being the Resident Care Coordinator or designee will audit hospice schedule 3x a month for 3 months & as need basis based on findings. Negative findings will be reported to the DON & reported at quarterly quality meetings. Element #5: The facility will be in full compliance with F-309 by 9/23/2016	

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F 309	Continued From page 21	F 309		

when they'll come or what they'll be doing.

On 8/31/16, at 10:07 a.m. a green hospice chart was found for R30 locked in the med room behind the facility nursing station. Review of this chart revealed hospice aides come to the facility on Tuesdays, and on Fridays an RN was scheduled to visit. The schedule lacked a time of day to expect this staff and the September calendar was blank.

On 8/31/16, at 10:20 a.m. licensed practical nurse (LPN)-B stated she knows when hospice nurses are coming, "When they show up." LPN-B stated maybe administration knows when to expect hospice, but she doesn't know in advance.

On 9/1/16, at 2:00 p.m., RN-A stated she talks to the hospice nurse about once a week, but didn't know how staff would know when hospice staff are coming.

On 9/1/16, at 2:00 p.m. the interim director of nursing (DON) stated the hospice agencies put a monthly calendar in the hospice chart. The DON did not know if the staff were aware of this or if they looked at the schedule. The DON stated this information was not in the report room where staff go to gather information at the start of their shifts.

RN-A stated R30's hospice agency was new to the facility so staff wouldn't know their days, but the other agencies that work at the facility have set days. RN-A stated R30's hospice staff come in the afternoon because that is when R30 is more alert and awake. RN-A did not know if this information was known to facility staff.

A policy on coordination of hospice care was

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F 309	Continued From page 22 requested but not received from the facility.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning according to the resident's assessed needs to prevent the development of pressure ulcers for 1 of 3 residents (R8) reviewed for pressure ulcers. Findings include: Pressure ulcer stages defined by the National Pressure ulcer Advisory Panel. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. R8's Face Sheet dated 8/31/16, indicated R8's diagnoses included hemiplegia and hemiparesis following cerebrovascular disease (stroke)	F 314	F-314 (D) Treatment/SVCS to prevent/heal pressure sores: Element #1: Staff on duty was informed of importance of offloading/repositioning resident #R8 as directed by plan of care and asking for assistance when needed. Element #2: All other residents that had potential to be affected by this deficient practice have been re-assessed by Resident Care Coordinator Element #3: To prevent this from happening again, education was provided to staff on duty on 8/31/16 & passed through report. Staff was also reminded of importance on 9/2/16, 9/9/16 and 9/23/16 via weekly Friday news publications. Staff was also educated on 9/19/2016 at the all staff neighborhood meetings. The facility	9/26/16

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F 314	Continued From page 23 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), chronic kidney disease, dysphasia (difficulty of discomfort with swallowing), long term anticoagulant use, pressure ulcer on the buttocks and pain. The quarterly Minimum Data Set (MDS) dated 6/20/16, indicated R8's long term memory was okay. R8 was able to recall the season, his room location, staff names and faces and knew he was in a nursing home. R8 did not have any behaviors or rejection of cares. R8 required the extensive assistance of 2 staff with bed mobility, transfers, toilet use and personal hygiene. R8 did not walk. R8 upper and lower extremities were impaired on one side. R8 was frequently incontinent of urine and always incontinent of bowel. R8 was at risk for pressure ulcers and had one unhealed stage two pressure ulcer. The oldest date of the pressure ulcer was 4/25/16 and R8 did not have any healed pressure ulcers. R8 had a pressure relieving device in the bed and the wheelchair and was on a turning and repositioning program. The significant change Care Area Assessment (CAA) dated 12/21/15, indicated R8 was at risk for pressure ulcers. R8 had multiple factors that put him at risk which included: limited mobility and required the assistance of two staff, occasionally incontinent of bowel and bladder, previous CVA with right sided hemiplegia, a history of pressure ulcers, R8 requested the head of the bed up when sleeping for comfort and had a right hand contracture. He had atrial fibrillation and was on Coumadin (a blood thinning medication), which put R8 at increased risk of bruising. R8 had a ROHO (pressure reducing air) cushion in the recliner and a pressure reducing	F 314	policy and procedure on pressure ulcers was reviewed. Element #4: To Maintain compliance with F 314, the RN or Wound Care Certified nurse will audit all residents with pressure ulcers monthly X 3 months, then quarterly X 3 months then on a as needed basis. The audit will consist of completion of tissue tolerance, skin/braden assessment, dietician consult and MD notification. All negative findings will be reported to the DON and at the quarterly quality meetings. Element #5: The facility will be in full compliance with F-314 by 9/26/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	09/01/2016

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

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F 314	Continued From page 24	F 314		

honeycomb cushion in wheelchair. R8 was to be offloaded and repositioned every two hours.
A Skin Assessment with a Braden Scale (a tool used to determine pressure ulcer risk) and Tissue Tolerance Assessment (a tool used to determine the ability of the skin and its supporting structures to endure the effects of pressure without adverse effects) dated 6/7/16, indicated R8 was at risk for pressure ulcers. Risk factors included; limited mobility, occasional incontinence, a previous CVA (stroke) which affected his right side,R8 requested to sleep with the head of the bed elevated and had a history of pressure ulcers. R8 was to be offloaded (to relieve pressure to an area for a minimum of one minute) or repositioned every one hour.
A Progress Note dated 8/30/16, indicated R8's right buttock had two small partial thickness areas with a periwound (the tissue surrounding the wound) which was purple in color and was 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.

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F 314	Continued From page 25	F 314		

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 ulcer on the left and right buttock and had a current pressure ulcer on the buttock. The care plan approaches included; a honeycomb pressure reducing cushion in the wheelchair and the recliner. A honeycomb sheet at the foot of the bed. The care plan further directed staff to reposition 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 7:05 a.m. R8 was observed in his room in bed,

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F 314	Continued From page 26	F 314		

the room was dark. At 7:10 a.m. NA-C entered the room with the mechanical lift. 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. Also present in the dining room was 6-8 other residents. Most of the tables were empty. At 7:45 a.m. staff took R8's breakfast order. At 7:55 a.m. R8 received his beverages. At 8:15 a.m. R8 received his breakfast. At 8:25 a.m. R8 received medication from the nurse. At 8:35 a.m. R8 was done eating and wheeled himself back to his room and remained in the wheelchair watching television until 9:01 a.m. when R8 put on the call light. NA-C entered the room and reassured R8 they were going to lay him down.

NA-C stated R8 got up in the wheelchair at about 7:30 and that was when R8 usually goes to the MDR for breakfast. NA-C verified R8 was to repositioned or offloaded every one hour. NA-C was aware R8 returned to his room at 8:35 a.m. but she was still assisting at breakfast. NA-C further stated she had another resident who was an every one hour repositioning and she had to reposition him also because he was late too. R8 was then transferred onto the bed with the mechanical lift. R8 was provided incontinence cares. R8 was observed sitting up in the wheelchair for 1 hour and 36 minutes without being repositioned.

At 9:10 a.m. R8's buttocks were observed with the interim director of nursing (DON). The DON cleansed the area of the buttocks to the right side of the coccyx. The area was covered with a white substance. The DON stated the white substance was Calmoseptine. Two open areas within a large purplish area were observed. The areas

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F 314	Continued From page 27	F 314		

measured:
1)1.5 cm by 0.5 cm.
2) 2 cm by 1 cm.
The DON applied the skin prep and the Calmoseptine cream to the area.

On 8/31/16, at 9:45 a.m. the DON verified R8 was to be repositioned or offloaded every hour. The residents who were hourly repositioning should be the last ones in the MDR and first ones out. If the resident was still eating the NA should approach the resident and offer repositioning. The DON further stated if the NAs were unable to get to the residents in time she would expect the NAs to ask the nurses to reposition residents and the activity staff can also help transfer residents.

On 8/31/16, at 1:10 p.m. licensed practical nurse (LPN)-B stated if the NAs were busy or assisting with meals, they would ask her to reposition the every one hour repositioning residents. .

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,

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F 314	Continued From page 28 indicated residents were to be turned and repositioned per the Tissue Tolerance Assessment.	F 314		

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	245454	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2016**

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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	K 000		

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

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

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K 000	Continued From page 1 Met.	K 000		

MDH
Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

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 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

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	00452	A. BUILDING: _____ B. WING _____	09/01/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 8/29/2016, through 9/1/2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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	2 000		

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2 000	Continued From page 2 MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide care and services as directed by the care plan for pressure ulcer interventions for 1 of 3 residents R8 reviewed for pressure ulcers. In addition, the facility failed to ensure 1 of 2 residents (R27) was included in activities outside of his room as directed by the care plan. Findings include: 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	2 565	Corrected	9/26/16

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2 565	Continued From page 3	2 565		

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 room and remained in the wheelchair watching television until 9:01 a.m. when R8 put on the call light. NA-C entered the room and reassured R8 they were going to lay him down. NA-C stated R8 got up in the wheelchair at about 7:30 and that was when R8 usually went to the MDR for breakfast. NA-C verified R8 was to repositioned or offloaded every one hour. NA-C was aware R8 returned to his room at 8:35 a.m. but she was still assisting at breakfast. R8 was then transferred onto the bed with the mechanical lift.

On 8/31/16, at 9:45 a.m. the director of nursing DON verified R8 was to be repositioned or offloaded every hour. The residents who were hourly repositioning should be the last ones in the MDR and first ones out. If the resident was still eating the NA should approach the resident and offer repositioning. The DON further stated she would expect staff to follow the care plan and if the NAs were unable to get to the residents in time she would expect the NAs to ask the nurses

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4 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 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 toileting. 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 several times 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 the activity room while out of bed. The group	2 565		

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2 565	Continued From page 5 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. SUGGESTED METHOD OF CORRECTION: 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.	2 565		

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2 830	Continued From page 6	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to honor bathing frequency choices for 3 of 3 residents (R12, R4 and R25). Findings include: R12's Face Sheet, indicated R12's diagnoses included, hemiplegia, hemiparesis and language deficits following a cerebral infarction (stroke), and mild intellectual disabilities. R12's quarterly Minimum Data Set (MDS) dated 7/13/16, indicated R12 was hard of hearing and had moderatively impaired cognition. R12's MDS also indicated he required one person to physically assist him with the activity of bathing. R12's care plan dated 10/8/15 indicated R12 required assistance with activities of daily living	2 830	Corrected	9/23/16

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2 830	Continued From page 7 (ADL's) including bathing, related to diagnoses of Parkinson's, CVA with left sided hemiparesis. R12's undated bath preference card indicated R12 preferred a bath. The preference card lacked information on the frequency of baths per week. On 8/30/16, at 11:47 a.m. family member (FM)-A stated R12 took two showers a week at home, on Tuesday and Saturday. On 8/31/16, FM-A confirmed that R12 had baths on Tuesday and Saturday at home, but took just one since moving to the facility. In a review of the facility's bath schedule for 8/29/16, to 9/1/16, R12 was scheduled for a bath on Monday, during the day shift. On 9/1/16, at 9:04 a.m., nursing assistant (NA)-D stated residents can have only one bath during the day shift. If a resident wants an extra bath it is the responsibility of the afternoon shift and they have a different schedule. There are only 2 residents that receive their baths in the evening now, and that is their only bath of the week, not a second bath. Those two residents just prefer to bath in the evening. NA-D stated the facility discontinued baths on Friday, Saturday and Sunday close to a year ago. On 9/1/16, at approximately 9:32 a.m. Employee (E)-B said the bath aide only works Monday through Thursday so that is when baths are scheduled. E-B stated 2 residents want their baths in the evenings, so those are done by nursing assistants, not the bath aide. E-B said they used to provide more than one bath a week, until about a year ago.	2 830		

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2 830	Continued From page 8 On 9/1/16, at 9:56 a.m. (NA)-D stated R12 hasn't asked for more baths, but she does remember R12 saying he took a bath on Monday and Saturday when living at home. R4's Resident Face Sheet indicated R4's diagnoses included chronic obstructive pulmonary disease, heart failure, depression, kyphosis, glaucoma and osteoporosis. The quarterly Minimum Data Set (MDS) dated 7/15/16, indicated R4 had no cognitive impairment, behaviors or rejection of cares. R4 needed the extensive assistance of one staff with activities of daily living and needed physical help of one staff with part 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. The Activities Social History and Preferences Assessment dated 6/28/16, indicated it was very important to choose type of bath and R4 preferred a tub bath. The assessment lacked the preference of the number of baths in a week. The Bathing Preference Card (undated) indicated R4 preferred to take a bath with the jets on and liked to be assisted with bathing while she relaxed in the tub with the jets on. The Bathing Preference Card lacked the preference of the number of baths in a week. The Bath Schedule (undated) indicated R4 was	2 830		

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2 830	Continued From page 9 scheduled to received her bath on Tuesday morning. On 9/1/16, at 9:10 a.m. nursing assistant (NA)-D stated R4 had not asked for an extra bath and the bath would have to be done on the afternoon shift. NA-D further stated, "R4 loves her bath." On 9/1/16, at 11:45 a.m. registered nurse (RN)-A stated she does resident care conferences and R4 had not requested an another bath during the week. R25's Resident Face Sheet indicated R25's diagnoses included muscular dystrophy, bursitis of the shoulder and ptosis (drooping of the upper eyelid) of bilateral eyelids. The significant change MDS dated 6/15/16, indicated R25 had no cognitive impairment. R25 needed the total assistance of two staff with bathing. On 8/29/16, at 4:10 p.m. R25 stated she only received a bath once a week and would prefer a bath twice a week. R25 stated when she first move in she received a bath two times a week but then the schedule changed and her bath was moved from evenings to days and now she only received a bath once a week. R25 stated everyone received their bath during the day. R25 was not told why, the bath scheduled changed but this was what they were doing. R25 stated she was not asked or told why the schedule had changed. R25 stated she took a shower every day at home. R25 further stated she has lived at the facility for 4 years and it had been a couple of years that she had been getting a bath one time a week.	2 830		

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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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2 830	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident preferences are honored. 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.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	2 900		9/26/16

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2 900	Continued From page 12 Based on observation, interview and document review, the facility failed to provide timely repositioning according to the resident's assessed needs to prevent the development of pressure ulcers for 1 of 3 residents (R8) reviewed for pressure ulcers. Findings include: Pressure ulcer stages defined by the National Pressure ulcer Advisory Panel. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. 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), chronic kidney disease, dysphasia (difficulty of discomfort with swallowing), long term anticoagulant use, pressure ulcer on the buttocks and pain. The quarterly Minimum Data Set (MDS) dated 6/20/16, indicated R8's long term memory was okay. R8 was able to recall the season, his room location, staff names and faces and knew he was in a nursing home. R8 did not have any behaviors or rejection of cares. R8 required the extensive assistance of 2 staff with bed mobility, transfers, toilet use and personal hygiene. R8 did not walk. R8 upper and lower extremities were impaired on one side. R8 was frequently incontinent of urine and always incontinent of bowel. R8 was at risk for pressure ulcers and had one unhealed stage	2 900	Corrected	

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2 900	Continued From page 13 two pressure ulcer. The oldest date of the pressure ulcer was 4/25/16 and R8 did not have any healed pressure ulcers. R8 had a pressure relieving device in the bed and the wheelchair and was on a turning and repositioning program. The significant change Care Area Assessment (CAA) dated 12/21/15, indicated R8 was at risk for pressure ulcers. R8 had multiple factors that put him at risk which included: limited mobility and required the assistance of two staff, occasionally incontinent of bowel and bladder, previous CVA with right sided hemiplegia, a history of pressure ulcers, R8 requested the head of the bed up when sleeping for comfort and had a right hand contracture. He had atrial fibrillation and was on Coumadin (a blood thinning medication), which put R8 at increased risk of bruising. R8 had a ROHO (pressure reducing air) cushion in the recliner and a pressure reducing honeycomb cushion in wheelchair. R8 was to be offloaded and repositioned every two hours. A Skin Assessment with a Braden Scale (a tool used to determine pressure ulcer risk) and Tissue Tolerance Assessment (a tool used to determine the ability of the skin and its supporting structures to endure the effects of pressure without adverse effects) dated 6/7/16, indicated R8 was at risk for pressure ulcers. Risk factors included; limited mobility, occasional incontinence, a previous CVA (stroke) which affected his right side,R8 requested to sleep with the head of the bed elevated and had a history of pressure ulcers. R8 was to be offloaded (to relieve pressure to an area for a minimum of one minute) or repositioned every one hour. A Progress Note dated 8/30/16, indicated R8's right buttock had two small partial thickness areas with a periwound (the tissue surrounding the wound) which was purple in color and was	2 900		

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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 ulcer on the left and right buttock and had a current pressure ulcer on the buttock. The care plan approaches included; a honeycomb	2 900		

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2 900	Continued From page 15 pressure reducing cushion in the wheelchair and the recliner. A honeycomb sheet at the foot of the bed. The care plan further directed staff to reposition 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 7:05 a.m. R8 was observed in his room in bed, the room was dark. At 7:10 a.m. NA-C entered the room with the mechanical lift. 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. Also present in the dining room was 6-8 other residents. Most of the tables were empty. At 7:45 a.m. staff took R8's breakfast order. At 7:55 a.m. R8 received his beverages. At 8:15 a.m. R8 received his breakfast. At 8:25 a.m. R8 received medication from the nurse. At 8:35 a.m. R8 was done eating and wheeled himself back to his room and remained in the wheelchair watching television until 9:01 a.m. when R8 put on the call light. NA-C entered the room and reassured R8 they were going to lay him down. NA-C stated R8 got up in the wheelchair at about 7:30 and that was when R8 usually goes to the MDR for breakfast. NA-C verified R8 was to repositioned or offloaded every one hour. NA-C was aware R8 returned to his room at 8:35 a.m.	2 900		

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2 900	Continued From page 16 but she was still assisting at breakfast. NA-C further stated she had another resident who was an every one hour repositioning and she had to reposition him also because he was late too. R8 was then transferred onto the bed with the mechanical lift. R8 was provided incontinence cares. R8 was observed sitting up in the wheelchair for 1 hour and 36 minutes without being repositioned. At 9:10 a.m. R8's buttocks were observed with the interim director of nursing (DON). The DON cleansed the area of the buttocks to the right side of the coccyx. The area was covered with a white substance. The DON stated the white substance was Calmoseptine. Two open areas within a large purplish area were observed. The areas measured: 1)1.5 cm by 0.5 cm. 2) 2 cm by 1 cm. The DON applied the skin prep and the Calmoseptine cream to the area. On 8/31/16, at 9:45 a.m. the DON verified R8 was to be repositioned or offloaded every hour. The residents who were hourly repositioning should be the last ones in the MDR and first ones out. If the resident was still eating the NA should approach the resident and offer repositioning. The DON further stated if the NAs were unable to get to the residents in time she would expect the NAs to ask the nurses to reposition residents and the activity staff can also help transfer residents. On 8/31/16, at 1:10 p.m. licensed practical nurse (LPN)-B stated if the NAs were busy or assisting with meals, they would ask her to reposition the every one hour repositioning residents. .	2 900		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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		

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21426	Continued From page 18	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		9/23/16
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R4, R8) had a baseline symptom screening for tuberculosis, and/or a first and second step Mantoux at admission to the facility. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline tuberculosis		Corrected	

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21426	Continued From page 19 (TB) screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms. R4 was admitted to the facility on 4/1/15. R4's medical record lacked documentation of a first and second step Mantoux upon admission. R8, admitted to the facility on 9/4/14. The medical record lacked documentation of TB symptom screening and a two step mantoux. On 9/1/16, at 3:25 p.m. the interim director of nursing (DON) verified she was unable to find documentation of R4's first and second step Mantoux and R8's TB symptom screening and a two step mantoux. The facility policy and procedure for Tuberculosis, Exposure Control Plan revised 4/16, lacked direction for reading and recording results of the TST. 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.	21426		

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21426	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN 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	21435	Corrected	9/23/16

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21435	Continued From page 21	21435		

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.

R27's Care Plan dated 6/15/16, specified R27 would answer simple yes or no questions and could put together short sentences when given time. The care plan also indicated R27 usually makes himself understood and understand information. The care plan also indicated much prompting was needed to get R27 out of his room. The care plan directed staff to bring R27 out of his room several times 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; R27 is on a 1:1 program with activities staff; and R27 participates in the Sensory Stem program. Finally, the care plan directed 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 the activity room while out of bed. The group sheet indicated R27 liked to people watch and was to be up in a wheelchair for every activity. The group sheet also directed staff R27 participates in "stem group" at 6:00 on Tuesdays and Thursdays.

On 8/30/16, at 2:54 p.m. R27 was observed in the recliner in his room, asleep. A Western show was on the TV in his room.

On 8/30/16, at 4:48 p.m. R27 was observed in bed in his room, asleep. The TV was on in his room, other residents were going into the dining

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21435	Continued From page 22 room in preparation for supper. On 8/30/16, R27 was observed in bed in his room asleep with the TV 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 a.m. R27 was observed awake in bed, with the TV on. From 8/31/16 at 8:51 a.m. until 9:08 a.m. a variety of activities were occurring in the facility: -residents were in the activity room doing independent activities (cards, reading the newspaper, coloring) -residents were sitting outside the nurses station waiting for their turn at the beauty shop and staff were coming and going. -3 residents were in the bird room waiting for an activity to begin. On 8/31/16, at 9:08 a.m. nursing assistant (NA)-B entered R27's room in order to check, change and reposition R27. NA-B told R27 that she was waiting for someone to help her and then they would check him and reposition him. NA-B donned gloves, gathered supplies and set up the supplies to check and change R27. NA-B did not engage R27 in conversation but stood, waiting until 9:18 a.m. when NA-B stated, they probably forgot about me and left the room to find assistance. NA-B returned with NA-A at 9:20 a.m., at which time they checked, changed and repositioned R27 in bed. After performing cares, NA-A and NA-B washed their hands, turned out the lights, left the TV on and left R27's room. At no time did either NA-B nor NA-A offer to get R27 out of bed or out of his room. NA-B and NA-A did	21435		

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21435	Continued From page 23	21435		

not engage R27 in conversation beyond the task of checking, changing and repositioning.

On 8/31/16, at 9:28 a.m. R27 was asked if he gets out of his room enough. R27's eyes got big and he quickly shook his head "no." When asked if he would like to get out of his room more often, R27 quickly nodded his head, "yes."

On 8/31/16, at 11:03 a.m. licensed practical nurse (LPN)-B exited R27's room. R27 remained in bed. LPN-B returned at 11:09 a.m. to give medications in R27's feeding tube.

On 8/31/16, at 1:05 p.m. R27 was observed in bed and the room was dark (lights off, window curtain pulled closed).

On 8/31/16, at 1:06 p.m. NA-B stated staff will get R27 into his recliner now and afternoon shift will get him up once too. NA-B stated those are the best time for R27.

On 8/31/16, at 1:46 p.m., when asked if he gets bored, R27's eyes widened and he nodded his head, "yes." When asked if he would like to get out more, R27 again nodded his head, "yes."

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.

During June of 2016, R27 had:
-4 days where his only activity was listed as TV
-6 days where his only activity was listed as resting, napping or sleeping.
-10 days with family or friends visiting
--10 days of facility activity involvement

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21435	Continued From page 24 (one-on-ones, music, etc.) In July of 2016, R27 had: --5 days in July where R27's only activity was listed as TV --11 days in July where R27's only activities were listed as rest, napping or sleep --A 5 day stretch from 7/3/16 through 7/8/16 where he only rested, slept or watched TV in his room. --10 days with family or friends visiting --10 days of facility activity involvement In August of 2016, R27 had: --11 days in August where his only activity was listed as TV --3 days in August where his only activity was listed as "rest" or "resting". --13 days with family or friends visiting --7 days of facility involvement. On 8/31/16, at 1:47 p.m. Activity Director (AD)-A confirmed R27's care plan states to assist him out of his room for all activities. AD-A stated she has had several conversations with nursing and left a note reminding them to also get R27 ready for Stem group, to have him up for games, but it doesn't happen. AD-A stated nursing indicated R27 refuses to come out but if approached, as his family has indicated, as let's just go do this (don't ask yes or no), R27 will enjoy himself once he's out and get more socialization. AD-A stated activities does a lot of one on one activities with R27, and most of them don't get charted. Activities staff will stop and chat with R27 if they see him awake in bed. On 8/31/16, at 1:54 p.m. registered nurse (RN)-A stated nursing and activities are to offer activities to R27. RN-A stated re-approach is a lot of it, and	21435		

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21435	Continued From page 25 staff are to encourage him to get up. RN-A stated once staff are able to get him up and out of his room, R27 enjoyed people watching and music. RN-A assumed staff were offering R27 an opportunity to get out of his room. Therapeutic Activities Program policy dated 6/2014, indicated residents of the facility shall be encouraged and given equal opportunities to participate in all activities of program. Activities Program policy, dated 6/2014, indicated that resident are informed of when group activities are occurring and are encouraged to be involved and physical assistance is provided. In addition, this policy indicted if resident appears to do no meaningful activity per their choice, staff approach and offer activities. Resident's refusal or acceptance is to be documented. Patterns of acceptance and/or refusals are to be documented in the care plan. SUGGESTED METHOD OF CORRECTION: The Activity Director or designee could develop, review, and/or revise policies and procedures to ensure resident's have an indivdualized activity program that meets their needs. The Activity Director or designee could educate all appropriate staff on the policies and procedures. The Activity Director or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		9/23/16

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21565	Continued From page 26 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 8/25/16, the physician ordered albuterol 2.5 milligrams (mg)/3 mililiters (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	21565	Corrected	

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21565	Continued From page 27 medical record lacked an order to SAM the nebulizer treatment. On 8/29/16, at 1:30 p.m. R12 was observed alone in his room in the wheelchair with his head down. The nebulizer was running via face mask and R12 appeared to be sleeping. Licensed Practical nurse (LPN)-B was at medication cart at the nursing desk and then walked to the other end of the hall. LPN-B did not return to R12's room until 1:41 p.m. when she removed the face mask and turned off the nebulizer machine. There were no other staff in the hall or near R12's room. On 8/30/16, at 10:08 a.m. R12 was observed again in his room in the wheelchair with his head down. The nebulizer was running via face mask and R12 appeared to be sleeping. LPN-B was at medication cart at the nursing desk. At 10:11 a.m. the interim director of nursing (DON) walked past R12's room to the end of the hall and back. At 10:17 a.m. LPN-B brought medications to the room across the hall from R12. At 10:23 a.m. LPN-B exited the room across the hall but did not check on R12 and the nebulizer treatment. LPN-B returned to the medication cart at the desk. At 10:26 a.m. LPN-B walked past R12's room, looked in and continued to the end of the hall and then walked back past R12's room to the medication cart at the desk. At 10:27 a.m. LPN-B entered R12's room. LPN-B stated, "it looks like you're done" and closed the door. On 8/30/16, at 2:30 p.m. LPN-B, verified she left R12 alone with the nebulizer treatment running. LPN-B stated she usually set up the nebulizer treatment, leaves him alone in his room and returns and removes the nebulizer treatment when it was done.	21565		

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21565	Continued From page 28 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 so. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		