DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 3, 2023

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: January 26, 2023

Dear Administrator:

On February 9, 2023, we notified you a remedy was imposed. On February 24, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 23, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 26, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 9, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 26, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 23, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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March 3, 2023

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

Re: Reinspection Results
Event ID: CSM812

Dear Administrator:

On February 24, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 26, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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February 9, 2023

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: January 26, 2023

Dear Administrator:

On January 26, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 26, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 26, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 26, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 26, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Centracare Health System-Sauk Centre Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 26, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 26, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	425 N ELM STREET SAUK CENTRE, MN 56378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/23/23-1/26/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/23/23-1/26/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H5341033C (MN82517) H53417700C (MN83305) H53417701C (MN83307) H53417702C (MN84644) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/15/2023

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 561		2/23/23

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F 561	Continued From page 2 Based on observation, interview and document review, the facility failed to ensure resident choices were honored for storage and access to personal property brought in to meet the residents' fluid intake preferences for 1 of 1 resident (R3) reviewed for choices. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/9/22, identified severe cognitive impairment with a diagnosis of heart failure. R3 required extensive assistance for most activities of daily living (ADL's) and R3 was usually understood. R3's MDS identified a life expectancy of less than six month. R3's Hospice Admission Visit note dated 3/1/22, indicated discontinuation of fluid restriction to promote comfort and quality of life. R3's care plan dated 12/12/22, identified, "Hospice: I am diabetic," "I can make my own food decisions, Exercise the right to not always follow my diet." R3's care plan dated 9/3/21, included to provide with a choice of snacks, "like diet coke." R3's Behavior Note dated 1/22/23, included, "Resident was upset after supper because he noticed his 24 pack and 12 pack of pop was taken out of his room. Staff labeled pop with residents name and put in the fridge. Resident stated that it belonged in his room and that he was going to call the cops if we didn't bring it back. Resident was yelling at staff and wouldn't let them explain that we shouldn't keep that much in his room so staff let resident calm down and	F 561	R3 was affected by this deficient practice and was interviewed by the DON on 1/24/2023. R3 was assessed for safety and deemed safe to have pop in his room, POA understands the risks of excessive pop intake, benefits of resident satisfaction outweigh the risk. Care plan was updated to reflect the resident choice to have pop stored in his room where he can have access to it when he wants. Resident and POA happy with the plan. The facility will review storage of food/beverage brought in for all residents to ensure residents have a choice for storage location. Residents who routinely have food/beverages brought in will have storage preferences care planned by 2/21/2023. Staff were provided education on resident rights and food preferences on 1/24/2023 at daily huddle and staff reviewed the Resident Rights Policy, the combined bill of rights, and answered a short quiz that was assigned on 1/24/2023 and due 2/17/2023. Survey findings were discussed at resident council on 2/7/2023. Resident individual preference will be reviewed with every care conference, if resident does not have any personal food/beverages this will not be noted. If there is a concern with resident food preferences and health risk or not aligned with nutrition orders then the IDT will determine next steps such as speaking	

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F 561	Continued From page 3 came back later. Last time resident had 2- 12 packs in his room he drank both of them within 2 days. Resident did not drink water during that time and was always incontinent through his (overnight) brief and pants even though he was toileted every two hours. Resident is also a diabetic and was previously on fluid restrictions. For the residents well being staff decided his pop should be put away and resident can then ask for one. When writer visited with resident after he was calm, he then understood that his pop has his name on it and is only for him, he just has to ask and staff can get it for him. No further behaviors." R3's Behavior Note dated 1/23/23, "Resident was upset that his pop was not in his room. Writer tried to talk with resident and let him know that we have it with his name on it and that he just needs to let us know when he would like one. Resident continued to be upset and said 'If I want my pop in my room I can have my pop in my room.' Staff did bring pop back into residents room." R3's Nurses Note dated 1/24/23, "In an unpleasant mood this morning. Not being very cooperative with NA [nursing assistant] as they reported. Pushing back on staff when trying to hook him up in the lift then wouldn't stand and when staff trying to adjust his leg so Hes standing properly on lift pad. Then getting angry at NA for assisting him with his positioning. Also reported that housekeeping staff asking resident if ok to mop the floors in his room. Resident stating that is ok so housekeeper starts to mop the floor and while she is doing these [sic] resident proceeds to run into her on purpose with his wheelchair multiple times."	F 561	with POA/Resident about risk versus benefits, updating medical provider, and ensuring resident choice is taken into consideration before implementing interventions. Care plan will be audited for each resident who was identified as having personal food or beverages brought in by 2/23/23 to ensure all care plans are up to date with resident preferences.	

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F 561	Continued From page 4 When interviewed on 1/24/23, at 11:15 a.m. nursing assistant (NA)-A stated, R3's pop had not been returned to his room at this time. R3 was to request from staff. When interviewed on 1/24/23, at 2:05 p.m. registered nurse (RN)-A. stated, R3 had a case of pop and drank it in two days. R3 Now usually gets about one a day. He is not able to keep in room due to lack of water consumption. RN-A was unsure if he prefers it to be cold. R3 does not have a refrigerator in his room. RN-A stated R3's pop is probably brought in by his power of attorney (POA) that is his good friend. It is R3's right to do so. However, RN-A identified that R3's is currently in the refrigerator down the hall. When interviewed 1/24/23, at 3:45 p.m. director of nursing (DON) stated she was aware likes to drink Diet Coke but does not drink water. In a recent interdisciplinary team (IDT) meeting it was noted that he went through a case in a few days. He is on hospice, and it was discussed to let him have his Diet Coke if he wants was the consensus with dietary staff present. DON stated it is noted that it helps his moods which can be "major" at times. The DON stated, unless the doctor ordered it to be taken away it should not be taken from him. DON indicated that she was not aware that it had been removed from R3's room. DON stated it should not have been removed. DON stated that if a resident is not cognitively intact we would need to discuss with the POA and physician prior to limiting his access or consumption. When reading R3's behavior notes DON stated, "that's awful." R3's Behavior Note dated 1/24/23, included, "Writer followed up with resident regarding his	F 561		

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F 561	Continued From page 5 pop. Asked if he approved where his pop currently is at in his room, He stated 'yep, I like it right where it is.' Verified he was ok with having it at room temp, he stated 'yep.' Encouraged resident to ask for ice if he wanted it cold. Resident was smiling ear to ear with no further concerns. Care plan updated." When interviewed on 1/25/23, 03:53 p.m. R3'S POA stated, she brings pop in for him when she visits ever since he was taken off of the fluid restriction in March 2022. She brings in enough to allow him two cans a day but states he does not have any self-control when it comes to his pop. So there are times that he will run out. The POA stated R3, "likes things his way or he gets mad." The POA was not aware that his pop had been removed from his room and stated it would, "upset him greatly." When discussing the recent behaviors reported the POA stated, "I'm sure it is about the pop." A resident choice policy was requested, but not provided by the facility.	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		2/21/23

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F 584	Continued From page 6 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a lift chair in good repair for 1 of 1 residents (R13) reviewed who utilized an electronic lift chair. Findings include: R13's face sheet printed 1/26/23, indicated R13's diagnoses included Parkinson's, anxiety,	F 584	R13 was affected by this due to increased risk of injury due to the cracked first layer of coating on the wires for the electrical remote. Head of Maintenance examined the chair, placed electrical tape over damaged cord for short term use and notified staff that family needs to replace the remote or remove the chair on 1/26/2023. Family chose to remove the	

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F 584	Continued From page 7 osteoarthritis, dorsalgia (low back pain) and weakness. R13's quarterly Minimum Data Set (MDS) dated 10/7/22, indicated R13 was able to communicate her needs. R13's cognition was intact. On 1/23/23, at 1:26 p.m. R13 was observed seated in the electronic lift chair in her room with the footrest elevated. The plastic covered wires for the remote were seen coming out of the remote. On 1/24/23, at 9:36 a.m. R13 demonstrated use of the remote for the electronic lift chair by lowering her legs. R13 stated she had no concerns with use of the remote, it worked each time she has tried it. R13 owned the chair. On 1/26/23, at 10:31 a.m. head of maintenance (HOM) stated all requests for repair of either resident owned items or facility owned items are submitted through the same process. HOM was not aware of R13's electronic lift chair needed repair. HOM confirmed the coated wires for R13's electronic lift chair were pulling out of the remote. HOM considered exposed, coated wires to be a high priority and should be repaired immediately. R13 was at risk for injury if the coating on the wires cracked or pulled off the wires. Facility policy, Electric Lift Recliners- Long Term Care revised 12/2021 indicated repair of privately owned lift chair is the responsibility of the resident but failed to provide direction regarding responsibility or a process to check the lift chair for need to be repaired.	F 584	recliner from the facility. Facility will check all electrical chairs belonging to the facility and to residents for safe functioning by 2/21/2023. Any chairs found to be a safety risk will be removed from use and either disposed of or properly fixed. If the resident owns the chair the chair will be removed from use and the family has the option to fix or remove from the building. Monthly safety walks will include a review of electric chairs being utilized in the facility. Education provided to environmental services and nursing staff to look at chairs when being used. If any cord is damaged the chair is to be unplugged and a maintenance ticket will be opened. The chair is not to be used until cleared by maintenance. Electric chairs will be added to nursing care plans by 2/21/2023 and audited for safety each quarter with their care conference, monthly safety walks will include looking at electric chairs, and staff will observe chairs when using. Staff will open a maintenance ticket when needed and unplug chair/remove from use until cleared by maintenance. This will be corrected by 2/21/2023. Weekly care plan audits will be completed following care conferences for a minimum of 4 weeks and will continue until facility reaches 100% compliance 2 weeks in a row. Will review current process and/or	

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F 584	Continued From page 8	F 584	provide coaching for any failed audits.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		2/9/23

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F 758	Continued From page 9 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess an increase in behaviors, failed to implement nonpharmacological interventions to ensure adequate medical justification prior to increasing an antipsychotic medication for 1 of 5 residents (R3) reviewed for unnecessary medication use. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/9/22, identified severe cognitive impairment with a diagnoses of heart failure and schizophrenia. R3 required extensive assistance for most activities of daily living (ADL's) and R3 is usually understood. R3's MDS identified a life expectancy of less than six month. R3 took antipsychotic medication for seven of the seven-day assessment period. Gradual Dose Reduction (GDR) has been documented as clinically contraindicated. R3's Mood State Care Area Assessment (CAA) for assessment reference date 3/11/22, identified a psychiatric disorder and was on antipsychotic	F 758	R3 had an increase in behaviors and pharmacological interventions were implemented prior to non-pharmacological interventions. R3 does have a diagnosis of schizophrenia with current use of antipsychotic medication and gradual dose reduction was documented as clinically contraindicated. On 1/30/2023 documentation does show ongoing behaviors that include: refusal of cares, short-tempered with annoyance, yelling, and screaming. 1/30/2023 consultant pharmacist reviewed medications related to behaviors. Documentation from pharmacist includes non-pharmacological interventions have been ineffective. 1/31/2023 facility RN and hospice RN assessed resident, reviewed notes, and hospice RN sent note to R3's psychiatrist related to current status and ongoing worsening of behaviors. R3 was seen by his routine psychiatrist on 2/9/2023 to review ongoing behaviors and mood, psychotropic medications were adjusted with plan to taper and initiate a different	

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F 758	Continued From page 10 medication. The CAA was not signed and there was no indication that this care area would be care planned. R3's Behavioral Symptoms CAA for assessment reference date 3/11/22, identified long standing mental health problems but this area would not be care planned. The CAA was not signed. R3's Psychotropic Drug Use CAA for dated 3/18/22, "resident admitted to Hospice 3/3/22 due to decline in overall health condition. Other diagnosis includes Schizophrenia. He is on a scheduled antipsychotic for this diagnosis. Proceed to care plan. Nurses give psychotropic medication per order. Monitor for effectiveness and for any adverse effects. Staff to monitor behaviors/mood, interventions and outcomes per Care Center protocol. Allow resident to vent/provide reassurance. DISCUS [screening for antipsychotic side effects] as warranted. Titrate medication as warranted and per M.D. order. Update primary M.D., Hospice and [power of attorney (POA)] with changes." Care planning to be completed for this area. R3's care plan dated 9/3/22 included "psychotropic drug use: potential for an alteration in cognition function/thought process r/t diagnosis of Schizophrenia. Resident has a history of delusions and hallucination. Zyprexa is given per order scheduled." Staff were directed to monitor mood and to titrate with physician as needed. R3's care plan failed to identify any behaviors toward others and failed to direct staff on how to prevent them from happening, or how to manage them when they occur. R3's Hospice Admission Note dated 3/1/22, lists,	F 758	pharmacological intervention. Behaviors continue to be monitored and as of 2/13/2023 no behaviors were exhibited in the last four days. Routine follow-up continues to be scheduled with psychiatrist and updates will be provided prn. Weekly behavior charting has been implemented for all residents who have a current prescription for any antipsychotic medication. Any physician order changes to antipsychotic medication will prompt nursing to start daily behavior charting for at least one week, then weekly if improvement in behaviors noted. The behavior monitoring note requires the nurse to address any potential side effects, any non-pharmacological interventions, and behaviors. CNAs also complete daily charting on all residents who have a current prescription for any antipsychotic medications which includes the behavior displayed and non-pharmacological interventions and their effectiveness. All changes in behaviors will be discussed at IDT to review current interventions and potential non-pharmacological interventions. Monthly behavior meetings are scheduled to review residents who trigger for antipsychotice medication and residents who trigger for behaviors. Findings are brought to quarterly QA meetings. Hospice RN will collaborate with facility RN or LPN prior to physician communication related to antipsychotic medications if patients are on hospice.	

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F 758	Continued From page 11 "78-year-old patient with history of Chronic Diastolic Congestive Heart Failure (CHF), type II diabetes and coronary artery disease (CAD). Hospice admission completed today with R3 in his room at the facility. His POA was updated following the admission who was in full agreement with comfort focused cares and the hospice admission as well. R3 was not very verbal, which is his baseline per the facility, but was quite clear in expressing his wishes to be comfortable and being ready to die. The staff reported to me, that he has also been giving away some of his most precious items to the POA over the course of the last weeks. R3 has been experiencing a slow decline over the past month per" documentation. R3's DISCUS Assessment dated 10/7/22 indicated no facial tics or grimaces. No eye blinking. No lip smacking or chewing, nor puckering, sucking, or thrusting of the lower lip. No tongue thrusting or tongue in cheek, nor tonic tongue, tremor, nor lateral movements noted. No head, neck or trunk abnormalities/movements. No upper or lower limb movements of concern noted. Antipsychotic Medication Evaluation Follow Up completed 12/6/22 indicated two episodes of behaviors of R3 yelling out at staff, hitting at staff, kicking at staff and one episode of pushing against the straps for the lift making it had for staff to unhook device. Review also indicated R3 has been on the current dose of 15 mg of Zyprexa (antipsychotic medication) once a day in the evening since 6/17/21. Also noted was Olanzapine (antipsychotic medication) has been trialed. R3's Care Conference Note dated 12/16/22,	F 758	DON or designee will audit antipsychotic medication adjustments to ensure an assessment is completed and demonstrates an increase in behaviors, implementation of nonpharmacological interventions are trialed (and effectiveness of those interventions), and to ensure adequate medical justification prior to increasing an antipsychotic medication. This audit will occur weekly for at least one quarter or until four medication adjustments pass the audit. Facility RN and Hospice RN collaborated to assess and provide care to R3 Documentation was shared with psychiatrist. On 2/9/2023 psychiatrist adjusted medications.	

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F 758	Continued From page 12 identified care plan reviewed and remained the same. R3's Orders Administration Note dated 1/21/23, "Zyprexa tablet Resident had a hard time getting medication down and stated that he did not want to take it." R3's Behavior Note dated 1/22/23, included, "Resident was upset after supper because he noticed his 24 pack and 12 pack of pop was taken out of his room. Staff labeled pop with residents name and put in the fridge. Resident stated that it belonged in his room and that he was going to call the cops if we didn't bring it back. Resident was yelling at staff and wouldn't let them explain that we shouldn't keep that much in his room so staff let resident calm down and came back later. Last time resident had 2- 12 packs in his room he drank both of them within 2 days. Resident did not drink water during that time and was always incontinent through his (overnight) brief and pants even though he was toileted every two hours. Resident is also a diabetic and was previously on fluid restrictions. For the residents well being staff decided his pop should be put away and resident can then ask for one. When writer visited with resident after he was calm, he then understood that his pop has his name on it and is only for him, he just has to ask and staff can get it for him. No further behaviors." R3's Behavior Monitoring dated 1/23/23, Behavior Exhibited "Initially refused to toilet and was upset with staff although he did toilet and had voided, upset that staff had taken pop out of his room but then had calmed down once staff explained his name was on it and he just needed to ask for it	F 758		

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F 758	Continued From page 13 and then this evening resident continued on about his pop not being in his room so staff did put his pop back in his room this evening." Frequency and impact to self or others indicated no risk at physical injury to self or others interfered with cares x1, Non-pharmacological Approaches/Effectiveness states, "Educated resident on importance of letting staff do cares. Pharmacological Interventions/Effectiveness lists Zyprexa 15 mg daily for Schizophrenia." R3's Behavior Note dated 1/23/23, "Resident was upset that his pop was not in his room. Writer tried to talk with resident and let him know that we have it with his name on it and that he just needs to let us know when he would like one. Resident continued to be upset and said 'If I want my pop in my room I can have my pop in my room.' Staff did bring pop back into residents room." R3's Nurses Note dated 1/24/23, "In an unpleasant mood this morning. Not being very cooperative with NA [nursing assistant] as they reported. Pushing back on staff when trying to hook him up in the lift then wouldn't stand and when staff trying to adjust his leg so Hes standing properly on lift pad. Then getting angry at NA for assisting him with his positioning. Also reported that housekeeping staff asking resident if ok to mop the floors in his room. Resident stating that is ok so housekeeper starts to mop the floor and while she is doing these [sic] resident proceeds to run into her on purpose with his wheelchair multiple times." R3's Orders Note dated 1/25/23, lists new orders "per Hospice, start Zyprexa 7.5 mg once daily in the morning."	F 758		

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F 758	Continued From page 14 R3's Behavior Note dated 1/25/23, "resident was resistive with toileting this afternoon yelling at aid when she had to change his pants and socks due to being soaking wet aid finally got him changed and tried to hook him back up to the EzStand (lift) resident shoved it toward her and told her she was being mean." R3's Hospice Note dated 1/25/23, "It is also reported that patient is having more behaviors. He has been resistive with cares. It is documented that he is trying to push the lift machine away when staff trying to hook him up also it is documented yesterday that housekeeping staff asked him if they could come and mop his floor which he agreed but then was purposefully running his wheelchair into the housekeeper multiple times. Last month on 12/14/22 we tried increasing his morphine thinking behaviors were possibly related to pain as he does have ongoing foot wound however his behaviors seem to be getting worse and his foot wound is looking better. I did update [primary physician] on behaviors and requested to possibly start a morning Zyprexa 7.5 mg and continue with the Zyprexa 15 mg at night awaiting response." R3's Behavior Note dated 1/26/23, "Writer followed up with resident regarding his pop. Asked if he approved where his pop currently is at in his room, He stated "yep, I like it right where it is." Verified he was ok with having it at room temp, he stated "yep." Encouraged resident to ask for ice if he wanted it cold. Resident was smiling ear to ear with no further concerns. Care plan updated." When interviewed on 1/25/23, at 1:45 p.m. hospice registered nurse (RN)-B stated she was	F 758		

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F 758	Continued From page 15 in to see R3 yesterday and reviewed the notes regarding recent mood/behavior of resident as well as the recent upset regarding his pop. RN-B stated they previously increased pain medication due to his behaviors and difficulty with communication. RN-B stated she requested an increase in Zyprexa due to recent increase in behavior frequency. She reported she has communication with R3's POA and they are ordering diabetic shoes as resident insists on wearing his shoes and they are ill-fitting due to foot wound. Stated she does speak with the nurses and nursing assistance when she is on site but all provider orders are requested by hospice nurses from the physician. She had reached out to the physician to request an increase in Zyprexa. Discussed possibility that behaviors were due to patient care rather than need for medication dose change and RN-B stated she will review R3's information. When interviewed on 1/25/23, at 3:53 p.m. R3's POA stated there is good communication with the care center staff as well as the hospice nurses in which she receives calls or texts with any information or updates. POA stated R3, "likes things his way or he gets mad." When asked about the recent removal of patients personal supply of soda, she was not aware of this and stated this would, "upset him greatly." When discussing the recent behaviors reported POA stated, "I'm sure it is about the pop". She stated she has seen him in one of his manic moods and he usually becomes very quiet and sullen. POA stated she is consulted regarding medication changes usually after the fact and has not had any discussions about a medication change at this time.	F 758		

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F 758	Continued From page 16 When interviewed on 1/26/23, at 9:04 a.m. nursing assistant (NA)-B stated, resident behavioral education is provided for all staff in upon hire and in general. She stated NA's pass on behavioral incidents to the nurses, who document in the resident record. NA-B states every resident has rights and they all should be kind to one another. NA-B stated she learned how to work with R3 with experience. NA-B stated she knows R3 doesn't mean what he says. She stated R3 loves his pop, and she can offer that to help diffuse a situation. NA-B stated R3 likes music and listening to the radio as well as crossword puzzles. NA-B stated this is all in the computer along with toileting and repositioning. When interviewed on 1/26/23, at 9:48 a.m. DON stated staff is to "Monitor mood and behavior per facility policy." DON stated they do not have target behavior monitoring or interventions. DON stated she is trying to implement this. DON informs that she has started monthly behavior meetings with the nurses a "couple of months ago" this review not documented in the resident chart. The nurses verbally discussion their resident concerns to collaborate. DON reviewed R3's medical record and was unable to find a comprehensive behavioral assessment or care planned interventions. DON also confirmed there was no interdisciplinary team (IDT) meeting completed to determine increased frequency or change in severity and no new nonpharmacological interventions were attempted prior to new hospice order for increase in antipsychotic medication. When interviewed on 1/26/23, at 11:07 a.m. RN-C stated, there is a verbal update with hospice staff while in the facility which is usually daily, or facility	F 758		

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F 758	Continued From page 17 staff will call the hospice nurse if they feel it is urgent. Facility staff does not call the physician directly, but hospice staff does take concerns to the physician and report back to the facility. Additionally, a verbal report is completed daily with the hall staff during walking rounds as well as the recently implemented monthly meetings with the DON. Monitoring for mood and behavior triggers on the Kardex (system of communication and organization used in nursing to relay important patient information and needs) if order is entered in the chart. This allows the staff to check off boxes accordingly while interacting with the residents. RN-C states they are working on transitioning to resident specific targeted behaviors with the specific patient needs and prevention as well as interventions. Hoping to change system wide to be more patient specific rather than broad as it currently is. When interviewed on 1/26/23, at 11:22 a.m. NA-A states she was "not really trained on behavior management and this was overwhelming at first." NA-A states that training upon hire was very broad addressing behaviors and how to respond. NA-A states that she feels more comfortable now as she knows the residents more. NA-A states she has not had issues with R3 on being physically aggressive toward her and he is usually only grumpy or verbally upset at times. NA-A states R3 has specific staff that he seems to not like and be more physically aggressive with. NA-A states she usually gets a verbal pass on during walking rounds updating on resident condition, mood, and behaviors. NA-A states that if there were an issue with any resident, she passes this on to the nurse right away and the nurses makes a note in the chart, as she can only click the appropriate	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	425 N ELM STREET SAUK CENTRE, MN 56378

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F 758	Continued From page 18 boxes. NA-A states if a resident is visibly or verbally escalating, she speaks calmly with the resident to try to calm them down. A policy for psychotropic medication requested but not provided by the facility.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		2/23/23

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F 880	Continued From page 19 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure proper gloving and hand hygiene was implemented during incontinent cares for 1	F 880	R1 room high touch areas cleaned on 1/26/2023.	

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F 880	Continued From page 20 of 8 residents (R1) observed for personal cares. Findings include: R1's quarterly Minimum Data Set (MDS) dated 11/11/22, indicated R1 was fully dependent on another person for physical assistance with toileting and personal hygiene. R1 was always incontinent of bowel and bladder and had a diagnosis of dementia. R1's care plan with last review date 12/5/22, indicated R1 required assist of one to two staff with peri cares and changing incontinent products. On 1/24/23, at 10:12 a.m. during observation of incontinent cares, nursing assistant (NA)-C clean bowel movement from R1's buttocks with her right hand and removed the soiled brief from under R1 with her left hand. Without changing her gloves, NA-C reached into R1's bedside table for a clean brief and placed it under R1. NA-C reached into the top drawer of R1's bedside table for a tube of barrier cream, then applied the barrier cream to R1's buttocks with her right hand. NA-C with assistance from NA-D rolled R1 side-to-side to adjust the brief, then assisted R1 with dressing upper and lower extremities. NA-C brought the wash basin to the bathroom and dumped the water into the sink. NA-C then assisted to straighten R1's sheet over him. NA-C removed the garbage with the soiled brief in it and placed it into a larger garbage can in R1's room. NA-C continued touching various items in R1's room including his tray table and bed controls. NA-C removed gloves when removing other personal protective equipment (PPE), the used hand sanitizer when leaving R1's room.	F 880	Current infection control training completion is 100% completed for facility staff as of 2/14/2023. Current hand hygiene audits show 75% compliance which identifies additional potential risk. Employees will review the perineal care policy and answer short quiz to show competency. Hand Hygiene Audits will be performed by the Infection Preventionist RN at least five times per week, nursing staff will also complete at least two audits per week ensuring all shifts are audited. Education will be provided if policy is not followed. Policy review and competency will be completed by 2/23/2023. The goal is 100% compliance after 6 weeks. If goal is not met, additional education will be provided and audits will continue until 100% compliance is achieved.	

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F 880	Continued From page 21 On 1/24/23, at 10:30 a.m. NA-C confirmed she did not change her gloves or clean her hands after assisting R1 with peri care following bowel incontinence. NA-C stated she knew she was expected to change her gloves after cleaning bowel, before touching clean items and to clean her hands each time she changed her gloves. On 1/26/23, at 11:50 a.m. director of nursing (DON) stated she expected gloves were changed after removing a soiled brief, especially after bowel incontinence. Hands should be cleaned anytime gloves are changed and when visibly soiled. Education has been provided to staff so they do not touch items in the resident's room after cleaning a resident up after incontinence, but especially bowel incontinence. DON stated it was important for staff to change their gloves and wash their hands to prevent possible spread of infection and to prevent contamination of other items in the resident's room. A facility policy for hand hygiene was requested but not received.	F 880		

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**01/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	**425 N ELM STREET** **SAUK CENTRE, MN 56378**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 01/24/2023, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Centracare Health Systems Sauk Centre Nursing Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. Centracare Health System Sauk Centre Nursing Home is a two-story building with no basement and is fully sprinkler protected. The original building was constructed in 1973 and was determined to be of Type II(222) construction. In 1994, an addition was added to the east that was determined to be of Type II(111) construction. In 2008 the facility moved the 2 hr separation in the West wing, adding six resident rooms to the Nursing Home. The addition was part of the original hospital constructed in 1949 and was determined to be of Type II (222) construction. The facility is fully fire sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one	K 000		

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

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

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**01/24/2023**

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K 000	Continued From page 1 building. The facility has a capacity of 60 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 9, 2023

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

Re: State Nursing Home Licensing Orders
Event ID: CSM811

Dear Administrator:

The above facility was surveyed on January 23, 2023 through January 26, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00640	A. BUILDING: _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTF	425 N ELM STREET SAUK CENTRE, MN 56378

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/23/23-1/26/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess an increase in behaviors, failed to implement nonpharmacological interventions to ensure	21535	Corrected	2/9/23

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21535	Continued From page 3 adequate medical justification prior to increasing an antipsychotic medication for 1 of 5 residents (R3) reviewed for unnecessary medication use. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/9/22, identified severe cognitive impairment with a diagnoses of heart failure and schizophrenia. R3 required extensive assistance for most activities of daily living (ADL's) and R3 is usually understood. R3's MDS identified a life expectancy of less than six month. R3 took antipsychotic medication for seven of the seven-day assessment period. Gradual Dose Reduction (GDR) has been documented as clinically contraindicated. R3's Mood State Care Area Assessment (CAA) for assessment reference date 3/11/22, identified a psychiatric disorder and was on antipsychotic medication. The CAA was not signed and there was no indication that this care area would be care planned. R3's Behavioral Symptoms CAA for assessment reference date 3/11/22, identified long standing mental health problems but this area would not be care planned. The CAA was not signed. R3's Psychotropic Drug Use CAA for dated 3/18/22, "resident admitted to Hospice 3/3/22 due to decline in overall health condition. Other diagnosis includes Schizophrenia. He is on a scheduled antipsychotic for this diagnosis. Proceed to care plan. Nurses give psychotropic medication per order. Monitor for effectiveness and for any adverse effects. Staff to monitor behaviors/mood, interventions and outcomes per Care Center protocol. Allow resident to	21535		

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21535	Continued From page 4 vent/provide reassurance. DISCUS [screening for antipsychotic side effects] as warranted. Titrate medication as warranted and per M.D. order. Update primary M.D., Hospice and [power of attorney (POA)] with changes." Care planning to be completed for this area. R3's care plan dated 9/3/22 included "psychotropic drug use: potential for an alteration in cognition function/thought process r/t diagnosis of Schizophrenia. Resident has a history of delusions and hallucination. Zyprexa is given per order scheduled." Staff were directed to monitor mood and to titrate with physician as needed. R3's care plan failed to identify any behaviors toward others and failed to direct staff on how to prevent them from happening, or how to manage them when they occur. R3's Hospice Admission Note dated 3/1/22, lists, "78-year-old patient with history of Chronic Diastolic Congestive Heart Failure (CHF), type II diabetes and coronary artery disease (CAD). Hospice admission completed today with R3 in his room at the facility. His POA was updated following the admission who was in full agreement with comfort focused cares and the hospice admission as well. R3 was not very verbal, which is his baseline per the facility, but was quite clear in expressing his wishes to be comfortable and being ready to die. The staff reported to me, that he has also been giving away some of his most precious items to the POA over the course of the last weeks. R3 has been experiencing a slow decline over the past month per" documentation. R3's DISCUS Assessment dated 10/7/22 indicated no facial tics or grimaces. No eye blinking. No lip smacking or chewing, nor	21535		

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CENTRACARE HEALTH SYSTEM-SAUK CENTF	425 N ELM STREET SAUK CENTRE, MN 56378

(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
21535	Continued From page 5 puckering, sucking, or thrusting of the lower lip. No tongue thrusting or tongue in cheek, nor tonic tongue, tremor, nor lateral movements noted. No head, neck or trunk abnormalities/movements. No upper or lower limb movements of concern noted. Antipsychotic Medication Evaluation Follow Up completed 12/6/22 indicated two episodes of behaviors of R3 yelling out at staff, hitting at staff, kicking at staff and one episode of pushing against the straps for the lift making it had for staff to unhook device. Review also indicated R3 has been on the current dose of 15 mg of Zyprexa (antipsychotic medication) once a day in the evening since 6/17/21. Also noted was Olanzapine (antipsychotic medication) has been trialed. R3's Care Conference Note dated 12/16/22, identified care plan reviewed and remained the same. R3's Orders Administration Note dated 1/21/23, "Zyprexa tablet Resident had a hard time getting medication down and stated that he did not want to take it." R3's Behavior Note dated 1/22/23, included, "Resident was upset after supper because he noticed his 24 pack and 12 pack of pop was taken out of his room. Staff labeled pop with residents name and put in the fridge. Resident stated that it belonged in his room and that he was going to call the cops if we didn't bring it back. Resident was yelling at staff and wouldn't let them explain that we shouldn't keep that much in his room so staff let resident calm down and came back later. Last time resident had 2- 12 packs in his room he drank both of them within 2 days. Resident did not drink water during that	21535		

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	00640	A. BUILDING: _____ B. WING _____	C 01/26/2023

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21535	Continued From page 6 time and was always incontinent through his (overnight) brief and pants even though he was toileted every two hours. Resident is also a diabetic and was previously on fluid restrictions. For the residents well being staff decided his pop should be put away and resident can then ask for one. When writer visited with resident after he was calm, he then understood that his pop has his name on it and is only for him, he just has to ask and staff can get it for him. No further behaviors." R3's Behavior Monitoring dated 1/23/23, Behavior Exhibited "Initially refused to toilet and was upset with staff although he did toilet and had voided, upset that staff had taken pop out of his room but then had calmed down once staff explained his name was on it and he just needed to ask for it and then this evening resident continued on about his pop not being in his room so staff did put his pop back in his room this evening." Frequency and impact to self or others indicated no risk at physical injury to self or others interfered with cares x1, Non-pharmacological Approaches/Effectiveness states, "Educated resident on importance of letting staff do cares. Pharmacological Interventions/Effectiveness lists Zyprexa 15 mg daily for Schizophrenia." R3's Behavior Note dated 1/23/23, "Resident was upset that his pop was not in his room. Writer tried to talk with resident and let him know that we have it with his name on it and that he just needs to let us know when he would like one. Resident continued to be upset and said 'If I want my pop in my room I can have my pop in my room.' Staff did bring pop back into residents room." R3's Nurses Note dated 1/24/23, "In an unpleasant mood this morning. Not being very	21535		

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21535	Continued From page 7 cooperative with NA [nursing assistant] as they reported. Pushing back on staff when trying to hook him up in the lift then wouldn't stand and when staff trying to adjust his leg so Hes standing properly on lift pad. Then getting angry at NA for assisting him with his positioning. Also reported that housekeeping staff asking resident if ok to mop the floors in his room. Resident stating that is ok so housekeeper starts to mop the floor and while she is doing these [sic] resident proceeds to run into her on purpose with his wheelchair multiple times." R3's Orders Note dated 1/25/23, lists new orders "per Hospice, start Zyprexa 7.5 mg once daily in the morning." R3's Behavior Note dated 1/25/23, "resident was resistive with toileting this afternoon yelling at aid when she had to change his pants and socks due to being soaking wet aid finally got him changed and tried to hook him back up to the EzStand (lift) resident shoved it toward her and told her she was being mean." R3's Hospice Note dated 1/25/23, "It is also reported that patient is having more behaviors. He has been resistive with cares. It is documented that he is trying to push the lift machine away when staff trying to hook him up also it is documented yesterday that housekeeping staff asked him if they could come and mop his floor which he agreed but then was purposefully running his wheelchair into the housekeeper multiple times. Last month on 12/14/22 we tried increasing his morphine thinking behaviors were possibly related to pain as he does have ongoing foot wound however his behaviors seem to be getting worse and his foot wound is looking better. I did update [primary	21535		

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21535	Continued From page 8 physician] on behaviors and requested to possibly start a morning Zyprexa 7.5 mg and continue with the Zyprexa 15 mg at night awaiting response." R3's Behavior Note dated 1/26/23, "Writer followed up with resident regarding his pop. Asked if he approved where his pop currently is at in his room, He stated "yep, I like it right where it is." Verified he was ok with having it at room temp, he stated "yep." Encouraged resident to ask for ice if he wanted it cold. Resident was smiling ear to ear with no further concerns. Care plan updated." When interviewed on 1/25/23, at 1:45 p.m. hospice registered nurse (RN)-B stated she was in to see R3 yesterday and reviewed the notes regarding recent mood/behavior of resident as well as the recent upset regarding his pop. RN-B stated they previously increased pain medication due to his behaviors and difficulty with communication. RN-B stated she requested an increase in Zyprexa due to recent increase in behavior frequency. She reported she has communication with R3's POA and they are ordering diabetic shoes as resident insists on wearing his shoes and they are ill-fitting due to foot wound. Stated she does speak with the nurses and nursing assistance when she is on site but all provider orders are requested by hospice nurses from the physician. She had reached out to the physician to request an increase in Zyprexa. Discussed possibility that behaviors were due to patient care rather than need for medication dose change and RN-B stated she will review R3's information. When interviewed on 1/25/23, at 3:53 p.m. R3's POA stated there is good communication with the care center staff as well as the hospice nurses in	21535		

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21535	Continued From page 9 which she receives calls or texts with any information or updates. POA stated R3, "likes things his way or he gets mad." When asked about the recent removal of patients personal supply of soda, she was not aware of this and stated this would, "upset him greatly." When discussing the recent behaviors reported POA stated, "I'm sure it is about the pop". She stated she has seen him in one of his manic moods and he usually becomes very quiet and sullen. POA stated she is consulted regarding medication changes usually after the fact and has not had any discussions about a medication change at this time. When interviewed on 1/26/23, at 9:04 a.m. nursing assistant (NA)-B stated, resident behavioral education is provided for all staff in upon hire and in general. She stated NA's pass on behavioral incidents to the nurses, who document in the resident record. NA-B states every resident has rights and they all should be kind to one another. NA-B stated she learned how to work with R3 with experience. NA-B stated she knows R3 doesn't mean what he says. She stated R3 loves his pop, and she can offer that to help diffuse a situation. NA-B stated R3 likes music and listening to the radio as well as crossword puzzles. NA-B stated this is all in the computer along with toileting and repositioning. When interviewed on 1/26/23, at 9:48 a.m. DON stated staff is to "Monitor mood and behavior per facility policy." DON stated they do not have target behavior monitoring or interventions. DON stated she is trying to implement this. DON informs that she has started monthly behavior meetings with the nurses a "couple of months ago" this review not documented in the resident chart. The nurses verbally discussion their	21535		

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21535	Continued From page 10 resident concerns to collaborate. DON reviewed R3's medical record and was unable to find a comprehensive behavioral assessment or care planned interventions. DON also confirmed there was no interdisciplinary team (IDT) meeting completed to determine increased frequency or change in severity and no new nonpharmacological interventions were attempted prior to new hospice order for increase in antipsychotic medication. When interviewed on 1/26/23, at 11:07 a.m. RN-C stated, there is a verbal update with hospice staff while in the facility which is usually daily, or facility staff will call the hospice nurse if they feel it is urgent. Facility staff does not call the physician directly, but hospice staff does take concerns to the physician and report back to the facility. Additionally, a verbal report is completed daily with the hall staff during walking rounds as well as the recently implemented monthly meetings with the DON. Monitoring for mood and behavior triggers on the Kardex (system of communication and organization used in nursing to relay important patient information and needs) if order is entered in the chart. This allows the staff to check off boxes accordingly while interacting with the residents. RN-C states they are working on transitioning to resident specific targeted behaviors with the specific patient needs and prevention as well as interventions. Hoping to change system wide to be more patient specific rather than broad as it currently is. When interviewed on 1/26/23, at 11:22 a.m. NA-A states she was "not really trained on behavior management and this was overwhelming at first." NA-A states that training upon hire was very broad addressing behaviors and how to respond. NA-A states that she feels	21535		

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21535	Continued From page 11 more comfortable now as she knows the residents more. NA-A states she has not had issues with R3 on being physically aggressive toward her and he is usually only grumpy or verbally upset at times. NA-A states R3 has specific staff that he seems to not like and be more physically aggressive with. NA-A states she usually gets a verbal pass on during walking rounds updating on resident condition, mood, and behaviors. NA-A states that if there were an issue with any resident, she passes this on to the nurse right away and the nurses makes a note in the chart, as she can only click the appropriate boxes. NA-A states if a resident is visibly or verbally escalating, she speaks calmly with the resident to try to calm them down. A policy for psychotropic medication requested but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication	21535		

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21535	Continued From page 12 ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		