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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Du9U

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245454**

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/13/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Susan Frericks, HPR SWS — 10/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 12/03/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/19/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245454

December 3, 2015

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 25, 2015 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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 27, 2015

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

RE: Project Number S5454025

Dear Mr. Hedrix:

On September 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 27, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On October 13, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 27, 2015, effective September 25, 2015 and therefore remedies outlined in our letter to you dated September 14, 2015, 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 letter / 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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245454	A. Building B. Wing	10/13/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 09/25/2015	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 09/25/2015	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 09/25/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By CC/mm	Date: 10/27/2015	Signature of Surveyor: 34983	Date: 10/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/27/2015		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: 5QF9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00452

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

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(L3) **ESSENTIA HEALTH - SANDSTONE**
(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 **08/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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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 Senior SWS 10/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 10/19/2015 (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
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3. Both of the Above :

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04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1300

September 14, 2015

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

RE: Project Number S5454025

Dear Mr. Hedrix:

On August 27, 2015, 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 actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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:

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 6, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 6, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 27, 2015 (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 February 27, 2016 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Sincerely,

Mark Meath

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

Enclosure(s)

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 _____	08/27/2015

RECEIVED
SEP 28 2015
MN Dept of Health
Duluth

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 a comprehensive assessment and appropriate implementation of a self-administration of medication program for 2 of 2 residents (R35, R13) who were observed to self-administer medications. Findings include: R35's annual Minimum Data Set (MDS) dated 8/27/15, indicated R35 was cognitively intact, had	F 176	**F-176 (D) Resident self-administer drugs if deemed safe:** Element #1: Resident # R35 and Resident # R13 were reassessed for appropriateness of SAM on 8/24/15. Based off the assessment completed on 8/24/15 self-administration of medications was discontinued for both of these residents. 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 8/24/15 and passed through report. Resident Care Coordinators completed current assessments on all other residents that SAM medications. The facility SAM policy was updated to include follow up action for all residents self-administering medications. Frequency of the	

10/8/15 OK - addendum E

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Landis RN/DON — TITLE: Director — (X6) DATE: 9/28/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	08/27/2015

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 no behaviors, and was able to eat independently after set up. R35's Face Sheet indicated diagnoses included dysphagia (difficulty swallowing), muscular dystrophy, muscle weakness, venous embolism (blood clots in the veins), pulmonary embolism/infarction (blood clots in the lungs). R35's care plan dated 10/23/12, indicated R 35 was able to self administer medications appropriately, after set up. A care plan revision dated 2/25/13, directed staff they may administer medications in the dining room. The signed physician orders dated 8/10/15, indicated R35 had an order to self administer medications after staff set them up. The physician orders included orders beginning 7/27/15, for Coumadin (blood thinner) 2.5 milligrams (mg) by mouth (po) once a day on Mondays and Fridays, and 5 mg on Sundays, Tuesdays, Wednesdays, Thursdays and Saturdays. The Coumadin levels were to be checked on 8/27/15. In addition, R35 had an order for Tylenol 650 mg po three times a day. A Self-Administration of Medication (SAM) Data Collection & Assessment form dated 12/11/14, indicated R35 was safe to be able to safely self-administer medications by the interdisciplinary team. The SAM assessment form lacked documentation assessment of R35's ability to take oral medications correctly after set-up by nursing. The electronic Medication Administration Record (EMAR) for 7/15, indicated it was OK to self administer medications after set up by staff. The	F 176	review pattern of the SAM process was changed to quarterly and with all significant changes. All nursing staff was educated on the policy change on 9/24/15 at a Mandatory staff meeting. Additional education was provided in 9/25/15 via weekly news publication "Friday Notes". Element #4: To maintain compliance with Self-Administration of medications the Resident Care Coordinators or designee will review all residents with a current SAM each month X 3 months, then as need based upon findings. 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-176 by 9/25/15.	

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	245454	A. BUILDING _____ B. WING _____	08/27/2015

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F 176	Continued From page 2 EMAR for 8/15 was requested, but not received. R35's progress notes dated 8/20/15, at 9:37 p.m. indicated the kitchen staff brought R35's medication cup from the table, still full of medication and pudding to the nurse. R35 said she had not seen the medication, but the medication cup had been placed directly in front of the food tray after R35 had received the food. The progress note indicated the nurse would continue to observe. During an observation on 8/24/15, at 5:16 p.m. licensed practical nurse (LPN)-A crushed R35's Coumadin and Tylenol and put them in a medication cup with approximately a teaspoon of pudding. LPN-A brought the medication cup and the cup of remaining pudding into the dining room, put them on the tray table next to R35's dinner plate, told R35 the medications were there, and left the dining room after R35 acknowledged the medications were there. LPN-A returned to the dining room at 5:23 p.m., but did not check on R35 to ensure the medications had been taken. At 5:27 p.m. R35 picked up the medication cup and ate the medications mixed in pudding with a spoon. Some of the green medication was still evident around the inside edge of the medication cup. Staff came to remove R35's cover up from around her neck and placed it over the medication cup. At 5:39 p.m. R35 left the dining room. On 8/24/15, at 6:00 p.m. LPN-A verified she had not followed-up to ensure R35 had taken the medications. The medication cup was still on the tray table in the dining room. LPN-A verified there was a significant amount of medication left in the cup, and stated it was Coumadin and a little	F 176	(This page is left intentionally blank)	

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F 176	Continued From page 3 Tylenol. LPN-A stated they would have to re-look at whether SAM is appropriate for R35. LPN-A further stated she did not want to give the remainder of the medication to R35 because the medication had been sitting unattended and there was a possibility someone could have tampered with it. LPN-A brought the medication cup to the director of nursing (DON) and asked if they should re-assess the SAM for R35. The DON verified SAM would need to be re-assessed for R35. On 8/24/15, at 6:45 p.m. LPN-A spoke with R35 and showed her how much of the medication she missed and talked to her about staff administering the medications. R35 agreed to allow staff to administer the medications. R35's progress notes dated 8/24/15, at 11:04 p.m. indicated R35 had left a small amount of medication in the pudding in the medication cup at supper, and R35 agreed to allow staff to be present when taking medication to ensure all medications were taken. An additional note on the electronic medical record dated 8/24/15, directed staff to be present during administration of crushed medications to ensure R35 fully empties contents of the medication cup. On 8/25/15, at 4:44 p.m. the DON verified R35 needed to be re-assessed for SAM, and someone else could have tampered with or taken the medication that was left unattended. R13's annual MDS dated 5/15/15, indicated R13 was cognitively intact, displayed no behaviors, and was able to eat independently. R13's Face Sheet printed 8/26/15, indicated	F 176	(This page is left intentionally blank)	

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F 176	Continued From page 4 diagnoses included shortness of breath, chronic pan, blepharoconjunctivitis (eye lid inflammation), and allergic rhinitis (allergies with nasal inflammation). R13's care plan dated 4/28/15, indicated R13 was able to self administer medications appropriately and instill eye ointments/drops and apply topical creams, and nebulizer treatments after set-up by nursing. The care plan indicted the interdisciplinary team would review SAM yearly and if changes in R13's condition. Signed physician orders dated 8/11/15, indicated R13 could self-administer mediations and treatments after set up by licensed staff. Medication orders included Gentamicin ointment 0.3%; apply 0.5 inch ribbon to both eyes at bedtime (4 p.m.), Beconase AQ 42 micrograms (mcg); one spray to each nostril twice daily at 6:00 a.m. and 4:00 p.m., and saline nasal mist 0.65%; one pray to each nostril twice daily at 9:00 a.m. and 4:00 p.m. The EMAR dated 8/1/15 - 8/26/15, directed R13 was able to self-administer medications and treatments after set up by licensed staff. A SAM Data Collection & Assessment form dated 2/18/15, indicated R13 was able to safely self-administer medications, including eye ointments/drops and inhalant medications. During an observation on 8/25/15, at 9:31 a.m. a bottle of saline nasal spray and Beconase, and a tube of Gentamicin ointment was sitting on the tray table in R13's room. R13 was in the room but left the room when the roommate entered the room. At approximately 10:00 a.m., the roommate	F 176	(This page is left intentionally blank)	

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F 176	Continued From page 5 left the room, also. The medication remained on the tray table. During an interview on 8/25/15, the DON stated residents were given education regarding SAM and were told to keep the medication in their sight when it is in their room. The DON verified the nurse needs to go back to check on the medication to ensure they took the medication and to remove the medications from the resident's room within a half an hour. The DON stated R13 did not want a locked drawer for bedside storage of medications in his room. On 8/26/15, at 8:47 a.m. R13 came to the desk to ask where his medications were that he usually has in the room. The nurse explained that they have to check up on his medications and make sure he took them. The nurse stated she would bring the nasal spray down in a little bit. R13 returned to his room. During an interview on 8/26/15, R13 stated the nurse usually picks up the medication soon after giving it to him, and stated he usually gives the medications to himself. During an interview on 8/26/15, at 2:22 p.m. nursing assistant (NA)-F stated R13 usually has medication stuff (nasal sprays, etc.) in his room all day, all the time. The policy and procedure for Self-Administration of Medications dated 4/14, indicated the SAM assessment would be conducted for the resident's quarterly care conferences and the results of the interdisciplinary team assessment were to be recorded in the resident's medical record. The policy and procedure directed	F 176	(This page is left intentionally blank)	

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F 176	Continued From page 6 residents are allowed to SAM when specifically authorized by the physician and in accordance with the facility procedures for SAM. The policy and procedure directed nursing staff to always observe the resident after administration to ensure that the dose was completely ingested and if only partially ingested, it was to be noted on the MAR, and action is taken as appropriate.	F 176		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide rising and morning routines in a dignified manner for 5 of 12 residents (R1, R4, R5, R15, and R33), who required extensive assistance to complete activities of daily living (ADL's). Findings include: During an observation of the 200 wing of the facility on 8/26/15, at 6:06 a.m. four residents were observed out of bed and dressed. During an observation of the 300 wing on 8/26/15, at 6:08 a.m. two residents were observed out of bed and dressed. During an interview on 8/26/15, at 6:19 a.m. nursing assistant (NA)-C stated, "The overnight	F 241	**F-241(E) Dignity and Respect of individuality:** Element #1: Resident # R1, R4, R5, R15 and R33 were removed from the scheduled night shift duty list. Element #2: All other residents that had potential to be affected by this deficient practice have been re-assessed for preference of rising time based off interview and or sleep study assessment. Element #3: To prevent this from happening again, education was provided to all staff on 9/2/15 during a mandatory staff meeting on resident rights, respect and preferences. Education was also provided on 9/25/15 in the weekly news publication "Friday Notes". Education provided included review of resident rights and implementation of a Dignity policy. During the meeting training was provided in regards to meeting resident's needs and conducting cares based off their preferences. Staffing models and patterns have been changed to meet the needs of the resident's preferences. A new Resident preference assessment will be conducted on all new admits, quarterly and with any significant change in status.	

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F 241	Continued From page 7 shift on my wing gets four residents up every day." She stated they had a list of who they were to get up, but was not sure what the criteria was for waking those residents first. During an interview on 8/26/15, at 6:28 a.m. NA-E stated the night shift had 5 people to get up on her wing. She stated if someone on her list has a bath that day, she is supposed to get someone else up. NA-E further stated all of the residents on her list use a mechanical lift for transfers, and if someone does not want to get up they are instructed to get a different resident up. During an interview on 8/26/15, at 6:37 a.m. NA-D stated on her unit, they get up four residents on the night shift and one resident gets washed and dressed in bed. She stated, "All of them are two person transfers, I start around 4:00 a.m. to get them ready because they all take a long time." NA-D further stated, "The people [residents] don't like it." A review of a facility document labeled ESSENTIA HEALTH-SANDSTONE HEALTH CENTER (NOC Duties) dated 7/20/15, indicated the night shift was to get 11 residents up daily and a twelfth resident on specific days. The document instructed the night shift: "If a resident not listed is awake prior to 6 am please complete their morning cares as an alternate for one on the list that is not awake." The document further indicated, "OK to wash dress and leave in bed" and "On bath days, select an alternate resident to get up." Included on the list of residents for the night shift to get up were: R1, R4, R5, R15, and R33. R1's annual Minimum Data Set (MDS) indicated	F 241	The preference assessment will allow the resident to determine they arise time in the am. Residents who are not cognitively able to answer will have a sleep study done to determine their typical wake up time. The NOC shift duty list has been updated and only the resident's cognitively able to state they would like to rise before 6 am have left on the NOC duty list. Element #4: To maintain compliance with resident dignity and audit of the Resident preference data collection will be conducted by the DON monthly X 3 months, then quarterly x 3 and then on an as needed based on findings. Element #5: The facility will be in full compliance with F-241by 9/25/15.	

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F 241	Continued From page 8 she was severely cognitively impaired and required extensive assistance of two staff to complete transfers, and extensive assist of one staff to complete all other ADL's. Her care plan (CP) dated 8/25/15, indicated R1 had unclear speech "most of the time", and had impaired decision making due to a diagnosis of dementia. R4's quarterly MDS dated 7/16/15, indicated she was severely cognitively impaired. Her CP dated 8/20/15, indicated she required extensive assist of one to two staff for dressing and extensive assist of two staff for transfers and toileting. R5's annual MDS indicated she was severely cognitively impaired. Her CP dated 7/24/15, indicated she required extensive assist of two staff for transfers using a mechanical lift. The CP further indicated R5 received end of life care with a goal of comfort. During an observation on 8/26/15, at 6:08 a.m. R5 was sitting, reclined in her wheelchair in front of the television in a common area. Resident was fully dressed and was sleeping. R15's annual MDS dated 7/20/15, indicated she was severely cognitively impaired and required extensive assistance for transfers with mechanical stand. Her CP indicated potential for impaired decision making related to diagnosis. R33's quarterly MDS indicated she was severely cognitively impaired. Her CP indicated she required extensive assist of two staff for morning and evening cares, and total assist of two staff for toileting and transfers. The CP further indicated R33 had difficulty making herself understood related to dementia.	F 241	(This page is left intentionally blank)	

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F 241	Continued From page 9 During an interview on 08/26/15, 9:51 a.m. the director of nursing (DON) stated residents are being awakened on the night shift per their choice, and a few were showing patterns of falling and had been added to the list. She had talked to some of them about their preference, but did not document any conversations. During an interview on 08/27/15, at 10:04 a.m. registered nurse (RN)-B stated, "If a resident is crawling out of bed, or awake at a certain time, or would prefer to get up early, staff will talk to the resident about getting up earlier or if a resident is having falls at a certain time attempting to climb out of bed, we would schedule them to get up on the night shift." RN-B further stated, "If everyone wanted to get up and get ready at 8:45 in the morning, we can't possible do it. Two aides cannot be expected to get everyone up at the same time." During a subsequent interview on 08/27/15, 1:55 p.m. the DON stated, "The schedule for residents getting up on the night shift changes frequently and the residents are evaluated ongoing." She added most of the residents were a fall risk at some point and were already awake at that time, and stated they had not reassessed their sleep patterns in a while. DON stated the nursing assistants can toilet them, wash and dress them and lay them back down. The DON further stated, "This was initiated because the day shift is not being able to get everyone up." A policy on dignity was requested, but not received.	F 241		
F 314	483.25(c) TREATMENT/SVCS TO	F 314	**F-314 Prevent/Heal pressure ulcers.**	

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F 314 SS=G	Continued From page 10 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 ensure 1 of 3 residents (R10) with pressure ulcers, were assessed, monitored and/or provided care to promote healing of current pressure ulcers and to prevent the development of new pressure ulcers. R10 developed recurrent pressure ulcers to the buttocks/coccyx area which caused actual harm for R10. Findings include: R10's Minimum Data Set (MDS) dated 5/26/15, indicated R10 was cognitively impaired, required extensive assistance with transferring and repositioning in bed and in wheelchair, and was at risk for pressure ulcer (PU) development. The MDS also identified R10 had diagnoses of diabetes, hypertension and dementia. The Skin Risk Assessment (with Braden Scale) dated 5/26/15, identified R10 was at risk for the development of PU's. R10's assessment indicated she currently had a "DTI [deep tissue	F 314	Element #1: Resident R10 was re-assessed by OT for proper wheel chair positioning; she was assessed by Dietician for wound healing on 8/27/15. RCC reassessed resident for appropriateness of sling remaining in chair after transfers, nursing order put in for nursing to monitor sling for proper placement (not between resident and pressure relieving cushion and sling if free of wrinkles or bunched areas that would cause pressure) after each transfer. Element #2: All other residents that had potential to be affected by this deficient practice have been re-assessed by Resident Care Coordinators. Element #3: To prevent this from happening again, all staff was educated on 9/24/15 on the process of evaluating sling placement after each transfer for all residents care planned to have sling left in place. This education included: sling must be removed from under the legs of all residents who are care planned to have sling left in chair after transfers, sling placement must be checked after each transfer to ensure the sling is not between the resident and any pressure relieving device, and the sling must be checked to ensure the sling is free from wrinkles or bunched up areas to prevent increased pressure to residents skin. All staff educated at this time that no items may be placed over pressure relieving/reducing devices; such as chux, dycem, towels ect. An additional area has been added to our current lift profile observation to specifically address risks and benefits of slings left in place after transfers. This will be completed on admit, quarterly,	

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F 314	Continued From page 11 injury] to left heel, open area to left gluteal fold near coccyx, dry scab to right outer ankle, moisture to abdominal folds." The assessment also indicated she had limited mobility, with potential problems of friction and shearing. "Maintains relatively good position in chair or bed most of time but occasionally slides down." Interventions included tissue off loading while in w/c (wheelchair), scheduled times to stay in bed off of buttocks, floating heel while in bed, and a heel protector. The 5/27/15, tissue tolerance assessment (determines skins ability to withstand pressure and determine appropriate repositioning intervals) indicated non blanchable redness was noted after a two hour observation. The nutritional high risk assessment completed on 5/28/15, identified a regular diet. The assessment indicated R10 had lost 10 pounds in the previous six months so was receiving glucerna (oral nutritional supplement) twice a day. R10's care plan reviewed 5/28/15, identified at risk for skin breakdown. The care plan directed staff to place a cushion in the w/c and recliner, apply barrier cream with pericares, pressure relieving honeycomb cushion in w/c, off load (relieving pressure to area to allow for tissue perfusion) every hour when in the w/c, reposition/offload every hour, w/c with lateral side supports for positioning, small piece of honeycomb to the inside heel of left shoe, float heel while in bed. The nursing assistant care sheet indicated hourly tissue offloading, leave sling behind her in w/c, toilet every hour when in the w/c. The medication administration history dated 4/15/15 to 4/30/15, indicated the nurses were monitoring three open areas on left buttocks until	F 314	significant change in status and with new skin impairments on residents that are care planned to leave sling in place. A new process was implemented between nursing and Therapy that includes; all Therapy recommendations for change in care planned interventions will be given to the Resident Care Coordinators or DON on a communication form to ensure the appropriate interventions are care planned and communicated to staff. The form includes a check off list for all staff involved in making the change to sign off on when complete. A nutrition assessment will be completed for all residents on admit, quarterly, significant change and with any new skin impairments. A tissue tolerance will be completed by Resident Care Coordinators or designee at a minimum of on admit, quarterly, annually, significant changes and with any new skin impairments. Element #4: To maintain compliance with F 314, the RN/Wound Care Certified nurse or designee will audit all residents with skin impairments. The audit will consist of completion of tissue tolerance, dietician consult, MD notification and IDT recommendations. These audits will be conducted monthly X's 3 months, then quarterly X's 3, and then on an as needed basis. 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 9/25/15.	

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F 314	Continued From page 12 they resolved. Laboratory results on 5/8/15 were as follows: albumin (the level of protein in the blood) 3.0 gram/deciliter (g/dL), normal was 3.5-5.0 g/dL; transferrin (plasma protein that transports iron through the blood) was 154 milligrams/deciliter (mg/dL), normal was 190-350 mg/dL. On 8/25/15, at 4:27 p.m. R10 was sitting in her wheelchair in the day room. The sling from her mechanical lift remained underneath her in the wheelchair. Observation on 8/26/15, at 6:21 p.m. R10 was sitting in the wheelchair in the hallway. The mechanical lift sling which is purple in color with a green ribbing around it remained under her in the chair. Below the sling was the pressure relieving cushion in the wheelchair. An interview on 8/26/15, at 7:32 a.m. licensed practical nurse (LPN)-B stated she had seen three open areas on R10's coccyx area the previous weekend. The treatment was to cleanse the area and apply sensicare. Observation on 8/26/15, at 10:20 a.m. registered nurse (RN)-A, RN-B, and nursing assistant (NA)-A were all present. The mechanical lift (maxi move lift) sling was observed to cross over R10's coccyx area. As R10 was lifted, the sling slid downward which created shearing over the coccyx area. The wound nurse measured the open area on R10's coccyx to be 1.2 centimeters (cm) long and 0.7 cm wide. The two other wounds were healed. R10 was assisted back to the wheelchair with a mechanical lift and the sling was left under R10. Under the sling was dycem, a thick plastic like sheet that reduces slipping. The pressure reducing cushion for the wheelchair was under the dycem.	F 314	(This page is left intentionally blank)	

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	245454	A. BUILDING _____ B. WING _____	08/27/2015

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F 314	Continued From page 13 On 8/26/15, at 1:03 p.m. RN-A measured R10's heel and ankle PUs. R10's left heel measured 1 cm in length and 1.8 cm width with 0.5 cm depth. RN-A stated the PU was slough filled. The PU was cleansed and hydrogell with tegaderm was applied. R10's shoe had a sheet of honey comb under the heel. RN-A measured the ankle PU to be 1.3 cm long and 1.1 cm wide with less than 0.1 cm depth. The PU was cleansed and a duoderm dressing was reapplied. Skin prep was applied to the surrounding skin. An interview with NA-A on 8/26/15, at 6:28 a.m. who stated the sling size was color coded. It was care planned to leave the sling under the resident. NA-A did not know how it was determined to leave a sling under a resident. During an interview on 8/26/15, at 7:23 a.m. LPN-C stated R10 had an open area on her left heel, an open area on the lateral ankle and three on her coccyx area. She said they apply sensicare cream with every change of her brief. A protective bandage was on her right inner thigh. LPN-C indicated the staff was not sure if the brief or the mechanical lift sling was causing that pressure ulcer, so the area was protected. During an interview on 08/26/2015, at 9:46 a.m. RN-A stated R10's last pressure ulcer was healed on 8/4/15, but the LPN found three open areas on the weekend of 8/22/15. RN-A measured them 8/24/15, which indicated "writer was alerted by staff that [R10] had 3 [three] open areas that were discovered over weekend on her coccyx/buttocks area. ...right upper buttock there is a 0.5 cm x 0.6 cm x 0.1 cm stage 2 pressure ulcer with light red wound base & on left buttock there is a 0.8	F 314	(This page is left intentionally blank)	

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F 314	Continued From page 14 cm x 0.2 cm x 0 cm superficial red wound base stage 2 pressure ulcer, just superior to this is another 0.5 cm x 1 cm x 0 cm stage 2 superficial red wound base." RN-A stated the three PU on the coccyx were related to friction, and the heel was pressure related. RN-A indicated no changes in care planned interventions were made at that time. During an interview on 8/27/15, at 7:59 a.m. RN-B stated the history of R10's PU since 5/15 was as follows: -5/5/15, there was a stage 2 PU (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) on the interior aspect of the gluteal fold 0.5 cm x 0.5 cm. Off loading was done hourly during the day and every two hours at night. Dietary was updated. R10 was on glucerna (supplement for diabetics) since 11/14. She was started on Juven (protein supplement) and due to side effects it was discontinued. No further dietary consults were made. At that time the left heel was a 6 cm x 7 cm deep tissue injury (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear). The skin was intact and skin prep was applied and a piece of honey comb was placed under her heel, inside her shoe. There was also a 2 cm x 2 cm mushy area on her right ankle. The area was covered with pilex for protection. Honey comb was placed on the end of her bed for heel and ankle protection. She has a pressure relieving mattress on her bed. Float heels at night. -5-13-15, a stage 2 pressure ulcer on top of gluteal fold was found measuring 0.4 cm	F 314	(This page is left intentionally blank)	

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F 314	Continued From page 15 diameter and superficial. An occupational therapy (OT) consult for w/c positioning was made. No other intervention changes were made. (OT consult dated 5-14-15, indicated that current foot positioning is impacting or contributing to wounds.) -5-19-15, one open area on coccyx measured 0.3 x 0.5. cm. The left heel was 3 cm x 4 cm dark purple deep tissue injury. The ankle area measured 0.2 cm x 0.3 cm. Will continue current treatment and continue tissue off loading. No change in assessment or intervention was made. -5-26-15, coccyx was a 0.3 cm x 0.5 cm stage 2 area. The area on the ankle was 0.2 cm x 0.3 cm area. The left heel area was 3.0 cm x 4.0 cm area. There was no change in interventions. -5-28-15, medical doctor (MD)-L saw R10's wounds and did not make any changes or write orders. No change in assessments or interventions. -6-4-15, coccyx stage 2 pressure ulcer is 0.3 cm x 0.3 cm wound bed was pink skin protector continued. Deep tissue injury to left heel was 2.8 cm x 4 cm with black eschar and mushy (per RN-B it is a change for the worse. It was firm but now mushy) MD-L recommended to let the ankle area dry out. No new skin assessments or changes in interventions were made. -6-10-15, was started on jueven, due to side effects it was discontinued and no replacement was started. R10 had received glucerna since 10/2014, and a multivitamin since 2014.	F 314	(This page is left intentionally blank)	

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F 314	Continued From page 16 -6-12-15, the PU on the coccyx was pinpoint but stage 2. The heel deep tissue area was 2.4 cm x 3.5 cm. The right ankle was 1 cm x 0.7 cm x 0.1 cm, the scab fell off leaving a slough filled wound bed. No change in assessment or intervention was initiated. -6-19-15, the coccyx measured 0.1 cm x 0.1 cm and superficial for depth. The deep tissue injury to heel 2.0 cm x 2.5 cm with black eschar. The right ankle area measured 0.8 cm x 0.8 cm x 0.1 cm. wound bed 100% slough. No change in assessment or intervention. -6-26-15, stage 2 pressure ulcer was less than 0.1 cm diameter. The deep tissue injury of left heel was 1.4 cm x 2.0 cm. The right ankle was 1.2 cm x 1.2 cm x 0.2 cm bed 50 % white slough and 50% granulation. No change in assessments or interventions were made. -6-30-15, the stage 2 coccyx area was resolved and closed. -7-2-15, a new pressure ulcer measuring 1 cm x 1.5 cm to right buttocks within 1/2 inch of previous wound. A 0.5 cm x 0.6 cm to left medial upper buttock area. The deep tissue injury left heel 1 cm x 2 cm eschar firm dry. The right ankle was 1.3 cm x 1.3 cm x 0.1 cm with a wound bed 20 % slough 80% granulation. There were no changes made in skin assessment or interventions. -7-6-15, a change for nursing to be present during the nursing assistants off loading was added per RN-B. This intervention was not on the care plan nor was the practice observed during the survey process. No new skin assessments or	F 314	(This page is left intentionally blank)	

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F 314	Continued From page 17 interventions were initiated. -7-7-15, the right upper coccyx stage 2 PU measured 1.0 cm x 1.8 cm . The left heel is 1 cm x 2 cm. The right ankle was 1.3 cm x 1.2 cm x 0.1 cm wound bed 20 % slough 80% granulation. There was no change to skin assessments or interventions. -7-12-15, another OT eval for wc positioning was sent. The results in the evaluation were "... Pt does not require skilled OT services at this time however will attempt to trial new pressure reliving cushion and continue to assist in position needs as able moving forward." (No documentation of the new cushion being trialed.) -7-13-15, a stage 2 pressure ulcer to right buttocks wound measured 0.8 cm x 1 cm x 0.1 cm. RN-A changed dressing from mepilex to hydrocolloid dressing. To be changed every five days and as needed. The deep tissue injury to left heel is 0.9 cm x 2 cm. The right ankle is 1.3 cm x 1 cm x 0.1 cm wound bed 20 % slough 80 % granulation scant amount drainage yellow on dressing. No change in skin assessments or interventions. -7-21-15, the right buttock measures 0.3 cm x 0.5 cm x 0 cm with no drainage. The left heel had the deep tissue injury measuring 1.3 cm x 2 cm. The ankle right was 1.4 cm x 1 cm x 0.2 cm with 20 % slough 80 % granulation. There was a scant amount of yellow drainage No change in assessment or intervention was initiated. -7-28-15, the right buttock PU was resolved and intact. The left heel was 1.5 cm x 2 cm dark brown mushy soft escar on top adhered to wound	F 314	(This page is left intentionally blank)	

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F 314	Continued From page 18 bed. The treatment to the heel was changed to periwound cleanser instead of skin prep. The right ankle was 1.4 cm x 1 cm x 0.1 cm with 20 % slough, 80 % granulation, and a scant amount yellow drainage. There were no changes in skin assessment or interventions. -8-4-15, the right buttock remained intact. The deep tissue PU on the left heel was 1.3 cm x 2.0 cm dark brown mushy on top 100% slough. The right ankle measured 1 cm x 1 cm x 0.1 cm and was 20 % slough. There were no changes in the intervention. -8-14-15, the left heel is 100% slough wound bed measured 1 cm x 2 cm. The right ankle was 1.2 cm x 1 cm by less than 0.1 cm. 100% granulation no drainage. There was no change in treatment. -8/19/15, the left heel was 1.2 cm x 1.5 cm depth 0.4 cm 100% stringy slough. The right ankle was 1 cm x 1 cm less 0.1 cm depth and the wound bed was 100% granulation with no drainage. There was no change in treatment. -8/22/15, the night nurse found 3 small open areas on upper buttock; the first was 0.8 cm x 0.6 cm, the second was 0.5 cm x 0.5 cm, and the third was 0.4 x 0.4 cm. The area was cleansed and skin protectant applied. -8/24/15, the wound nurse measured the wounds and noted the right upper buttock stage 2 PU to be 0.5 x 0.6 cm, less than 0.1 cm depth, with a red wound base. The left buttock stage 2 PU measured 0.8 cm x 0.2 cm, had no depth, and was superior to the third stage 2 PU that measured 0.5 cm x 1 cm, and had no odor or	F 314	(This page is left intentionally blank)	

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F 314	Continued From page 19 drainage. RN-B said, "We think its from friction"... [R10] rocks sometimes." An air mattress on bed. The current pad in the wheelchair was the same honeycomb pad. There was no documentation indicating why the pad was not changed to ROHO as suggested by OT. There was no reassessment or change in interventions despite the reoccurrence of pressure ulcers to the buttocks/coccyx area. During an interview on 08/27/2015, at 9:41 a.m. RN-B said she didn't have any ideas of what to change for interventions. During an interview on 08/27/2015, at 10:00 a.m. registered dietician (RD)-C stated R10 was on a glucerna supplement since October 2014. She said they attempted to give her jueven (to add additional protein for healing) but R10 was unable to take it due to side effects and no other change in supplement has been attempted. During an interview on 08/27/2015, at 11:20 a.m. RD-E stated R10 was not getting any protein fortified foods. She said R10 eats well. During an interview on 8/27/15, at 1:15 p.m. RD-C stated she looks at the percentage of eaten food, which was monitored but had not calculated the protein intake for a while. She said the protein measure is "a poor indicator of nutritional status." She said that after reviewing R10's intake she needed more protein added and stated beneprotein would be added to her diet. RD-C also agreed R10 was high risk for nutrition and PU. RD-C also acknowledged there was no nutritional assessment note since 5/28/15. During an interview on 08/27/2015, at 11:06 a.m.	F 314	(This page is left intentionally blank)	

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F 314	Continued From page 20 occupational therapist (OT)-D said R10 tends to lean to the side. She did an evaluation on April 17, 2015. At that time she added a bolster cushion over the arm rest, and she put a foam cushion insert on both sides of R10 to minimize leaning to the sides. She said there was no documentation that suggested a ROHO pad was put into the wheelchair, how the honey comb was restarted, or if it had ever been changed. OT-D said she made a recommendation to not have the sling under R10. OT-D was not aware of any assessment that was completed to determine the sling could safely stay under R10 when sitting. During an interview on 08/27/2015, at 10:04 a.m. the director of nurses (DON) said they have tried all of the interventions to minimize PU they can think of. She said she was not aware of any assessment to determine if it is safe to have the sling under the resident but they did care plan it. She said it is also care planned to offload every hour. She also stated her expectation is for assessments quarterly, annual and when significant change has occurred on the residents. She was not aware of why there was no recent dietary or nursing assessment. She was not aware there were no recent laboratory results. She verified there were no assessments of the efficacy of having the extra green sheet on top of the wheelchair pad and under the sling, which are all under the resident. During an interview on 08/27/2015, at 1:33 p.m. RN-B stated they normally do a tissue tolerance when there is any new skin breakdown. She said she did one yesterday because it was due for the quarter, not because of new skin breakdown. She went on to say they are suppose to do skin assessments whenever there is new skin	F 314	(This page is left intentionally blank)	

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F 314	Continued From page 21 breakdown. RN-B stated they usually get new laboratory tests completed when there is new skin breakdown and acknowledged there had not been any new tests since last May. RN-B further verified R10 had not received any new protein supplements. A policy entitled: Pressure Ulcer and Non-Surgical Wound Documentation, revised 2/15, indicated a dietician to review nutrition/hydration status and make recommendations to promote healing. Monitor and document as needed.	F 314	(This page is left intentionally blank)	

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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 55 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is Met.	K 000		

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