



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 29, 2025

Administrator
Sacred Heart Care Center
1200 12TH STREET SOUTHWEST
AUSTIN, MN 55912

RE: CCN: 245447

Cycle Start Date: July 25, 2025

Dear Administrator:

On September 15, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2025

Administrator
Sacred Heart Care Center
1200 12TH STREET SOUTHWEST
AUSTIN, MN 55912

RE: CCN:245447

Cycle Start Date: July 25, 2025

Dear Administrator:

On July 25, 2025, a 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 25, 2025, (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).

In addition, if substantial compliance with the regulations is not verified by January 25, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

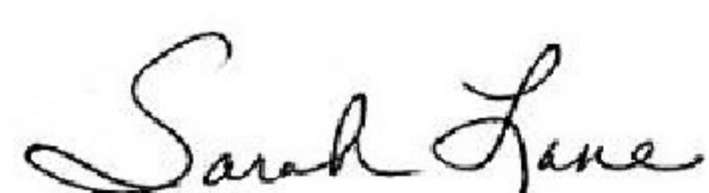
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
E0000	Initial Comments On 7/21/25 to 7/25/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.		E0000			08/25/2025	
F0000	INITIAL COMMENTS On 7/21/25 to 7/25/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54479516C (iQIES #1193376, MN00114486). NO deficiencies were cited. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000			08/25/2025	
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with		F0645	F645 R3 had an updated level 1 Pre-admission screening and resident review (PASARR) completed on 8/15/25. The documentation from level 1 PASARR has been sent to the		08/25/2025	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
F0645 SS = D	Continued from page 1 a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,		F0645	Continued from page 1 referring agency to schedule and complete level 2 PASARR. Social services coordinator will follow up daily with referring agency to ensure level 2 PASARR is scheduled and completed. Mood and Behavior Policy and Procedure was reviewed and updated on 8/20/2025. Social services admission checklist updated to include checking for level 1 and level 2 (if applicable) PASARR are completed. All current residents in the facility will have their PASARR audited to determine if any additional level 2 are needed. Audit was initiated on 8/20/25 and will be finished by date of completion. Risk of re-occurrence will be minimized by the Administrator or designee initiating the following: All social services coordinators will be re-educated on the facility policy Mood and Behavior by date of completion. Education of the policy was initiated on 8/20/2025. Education included: ensuring a level 1 PASARR is completed for all new admissions, completing a level 2 PASARR as indicated before admission to the facility. Audits will be completed once weekly for 3 months on all new admissions to ensure PASARR are completed per policy. Audits ongoing until reviewed at QA until determination made is no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: 8/25/25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
F0645 SS = D	Continued from page 2 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a Level II Pre-admission Screening and Resident Review (PASARR) was completed for 1 of 2 resident (R3) reviewed for PASARR R3's Minimum Data Set (MDS) assessment dated, 4/23/25, indicated R3 had intact cognition, adequate hearing, clear speech, can understand others, and able to make needs known. R3 was admitted on 1/31/23 with diagnoses of Personality Disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems), Suicidal Ideation ((SI) thinking about or planning to harm yourself), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Generalized Anxiety Disorder (mental health condition characterized by persistent and excessive worry about a variety of events or activities), and Post-traumatic Stress Disorder (mental health condition that can develop after experiencing or witnessing a traumatic event). R'3 current medications include hydroxyzine for general anxiety disorder and imipramine for major depressive disorder. Facility document titled, "Senior 'LinkAge" Line dated			F0645			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912		
(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	
F0645 SS = D	Continued from page 3 1/30/2023, indicated R3 had a primary diagnosis of severe major depressive disorder. "Yes" for R3 having a current diagnosis of a mental illness. "Yes" for R3 having a mental illness as the primary diagnosis for hospitalization. "Yes" for R3 having a mental illness that has significantly interfered with functioning. "Yes" for R3 needing supportive services or interventions due to a mental illness. The document indicated R3's provided information met criteria for Mental Illness (MI) and needed to be referred to lead agency for further evaluation (level 2 PASARR). During interview on 7/24/25 at 9:19 a.m., assistant director of nursing (ADON) confirmed R3's level 1 PASARR was completed on 1/30/23; indicating R3 met criteria for a level 2 PASARR. ADON confirmed R3's level 2 PASARR had not been completed. During interview on 7/24/25 at 9:29 a.m., director of nursing (DON) and regional consulting registered nurse (RC-RN) confirmed R3's admission diagnosis and R3 met the criteria for completing a level 1 PASARR. DON and RC-RN confirmed R3 had a completed level 1 PASARR dated 1/30/23. DON and RC-RN confirmed the level 1 PASARR indicated R3 should have a level 2 PASARR. DON and RC-RN confirmed the level 2 PASARR had not been completed. An undated facility policy titled Mood and Behavior Policy, the facility will complete a level 1 PASARR for all new admissions, completing a level 2 PASARR as indicated before admission to the facility.	F0645			
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a process was in place to maintain 4 of 4 MedCare mechanical lifts and 2 of 4	F0689	F689 Policy and procedure, Mechanical Lift Inspection Policy and Procedure reviewed and updated on 7/23/2025. Policy and procedure, Lift Machine, Using a Mechanical reviewed and updated on 7/23/2025. All lifts were immediately removed from service on 7/23/2025, until inspected and approved for use. Rubber stoppers on the 4-point sling support neck have been installed on all mechanical lifts and sit to stand lifts. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) Maintenance personnel re-educated on facility	08/25/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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)	
F0689 SS = E		Continued from page 4 MedCare sit to stands. This practice had the potential for unsafe transfers of 11 of 11 residents (R6, R16, R19, R23, R27, R35, R38, R42 R4, R20, R33) when it was identified the equipment used was missing safety parts used to help prevent accidents and hazards and equipment was not routinely maintained per manufacturer's recommendation. Finding includes: R6, R16, R19, R23, R27, R35, R38, R42, R4, R20 and R33, care plans included nursing staff to provide 2-person assistance for transfers and mobility either with a mechanical lift or a sit to stand lift. During an observation and interview on 7/21/25 at 1:42 p.m., nursing assistant (NA)-B identified 2 mechanical lifts labeled 31, 32 and a sit to stand lift numbered 30 missing rubber sling stoppers on the 4-point sling support hook. NA-B indicated a few of the mechanical lifts in the facility had rubber sling stoppers in place and nursing staff are directed to use the mechanical lifts for resident transfers. NA-B acknowledged the rubber sling stopper were to prevent the slings from sliding out of the sling support bar during transfers and to prevent resident falls from the lift, if not properly secured. During an interview on 7/22/25 at 8:32 a.m., maintenance technician identified the facility administration informed him the rubber sling stoppers were to be ordered and placed on the mechanical lifts. Several of the lifts had received rubber sling stoppers, however, the facility was awaiting delivery of additional rubber sling stoppers to be applied to the remainder of the lifts. He was aware the nursing staff were to use the mechanical lifts and identified routine maintenance checks and cleaning was needed for all lifts on a routine basis. Further observation on 7/22/25 at 9:22 a.m., wing three (3) had two (2) mechanical lifts with number 26, 27, and a sit to stand numbered 28, all included serial numbers on the labels, and all missing rubber sling stoppers. During an observation on 7/22/25 at 9:48 a.m., NA-C and NA-Z went in to assist R27. NA-B and NA-Z applied a yellow sling sheet under R27's back. The mechanical lift number 31 was used and was noticed to be missing the rubber sling stoppers. R27 was lifted off the bed and was transferred to R27's wheelchair. Review of a Check off List for Lifts 2025,		F0689		Continued from page 4 policy, Mechanical Lift Inspection Policy and Procedure. The training of this policy was completed on 7/23/2025. 2)Preventive checklist obtained from lift manufacturer's manual. Preventive maintenance checklist was completed for each lift by maintenance personnel on 7/23/2025. Lifts that were deemed safe were reinstated in service. Lifts that were over ten years old were removed from service permanently. Preventive Maintenance Checklist records for each lift to be filed and maintained. 3) All clinical staff (RN's, LPN's, TMA's, and CNA's) will be re-educated on the facility policy, Lifting Machine, Using a Mechanical. The education includes review of entire policy and procedure including ensuring rubber stops are always on before use and how to identify and report lift maintenance concerns. The education on this policy was initiated and competency demonstrated beginning on 7/23/2025 and will be completed by date of compliance. Staff that have not yet been scheduled to work prior to compliance date will complete education prior to their next scheduled shift. 4) Each Lift will be randomly audited three times weekly for 3 months to ensure rubber stops are securely in place. These results will be brought to QA meetings for review. 5) Lift preventive maintenance checklist will be completed monthly, and audits will be brought to QA monthly for review to discuss findings and need for further auditing and/or additional staff training. Date of completion: 8/25/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
F0689 SS = E	Continued from page 5 identified number 26, 27, 31, and 32, had a routine safety check completed in the month of July. Review of Check off list for Stands 2025, identified 28 and 30 had a routine safety check completed in the month of July. Prior months Check off List for January through June 2025 lacked evidence safety checks were completed on the mechanical lifts to determine if the equipment was appropriate for resident use. Interview on 7/22/25 at 1:03 p.m., maintenance director who had been employed for two months had no formal training of lift maintenance, upon hire. The mechanical lifts safety check was completed once after he started and was for the month of July 2025. In addition, the facility records lacked documentation of a lift maintenance program. He identified the facility had no process in place to ensure the mechanical lift devices were checked monthly for resident use. Interview on 7/22/25 at 2:34 p.m., MedCare sales representative identified the facility's mechanical lift with serial number 0203LF0412 labeled #32, was manufactured in 2002 and was 22 years old. She identified mechanical lifts was designed to last 20 years, however, after 10 years they recommend the lift to be replaced. Although after 10 years, the mechanical lift may continue to be used, provided routine maintenance was performed to ensure the integrity of the structure and function of the lift. If, routine maintenance was not performed on a routine basis, the mechanical lift was to be pulled out of service. In addition, the company stopped providing routine maintenance checks on mechanical lifts in 2018, however, the company would need to make arrangements for an authorized dealer in the local area to provide checks upon request from the facility. Follow up interview on 7/22/25 at 4:32 p.m., with maintenance director identified he was not aware one of the mechanical lifts was expired and had no knowledge of how to verify when a lift was expired. He previously, sent an email to the manufacture to verify information of the lifts used at the facility and had not received a reply, however the lift remained on the unit for use. When asked about the expired mechanical lift that had not received routine safety checks, was it safe for resident use, he had no response. He acknowledged he recently created a checklist based on the MedCare Manufacturer's preventative checklist for lift maintenance and safety check. However, his checklist did not include the manufacturer's			F0689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
F0689 SS = E	Continued from page 6 recommendation to contact a safe patient handling consultant for lifts beyond the life expectancy of 10 years. Interview on 07/22/2025 5:32 p.m., with LPN-B and NA-D both identified the rubber sling stoppers was not placed on all the mechanical lifts. Interview on 7/23/25 at 10:37 a.m., with director of nursing (DON) identified, several months prior, the facility lacked a thorough training plan for new hires that was to include components of nursing care, including use of facility equipment that was used for residents. The facility implemented a performance improvement project (PIP) to identify current training processes and improve onboarding practices and staff knowledge to safely provide quality care to residents. During a follow up interview on 7/23/25 at 10:49 a.m., MedCare sales representative identified the rubber sling stoppers was an added safety precaution that was implemented for all mechanical lifts to prevent the slings from sliding off. In addition, she identified residents who use the full body mechanical lift was at a higher risk of falling out of the lift when the rubber sling stoppers was missing from the mechanical lift. Notification regarding discontinuation of lifts, services, and parts availability was sent in a mass email to all facilities on record. Interview on 7/23/2025 4:40 p.m., the administrator was unsure if the facility had reached out to the mechanical lift manufacturer to provide a mechanical service part evaluation on the lifts prior to their employment. She was aware the facility had a monthly checklist for routine maintenance to be completed on all lifts that was implemented by the maintenance director. However, she had no knowledge the facility had an older lift, not routinely checked for maintenance and remained in service on the units. The facility held a mandatory skills training in July 2025 for nursing staff to be educated on the mechanical lifts, however, she identified nursing staff could return to work and continue to transfer residents with the mechanical lifts, even though the mandatory training was not completed for all employees. She acknowledged, it would be difficult for nursing staff to identify and voice maintenance concerns when they have not received appropriate training on equipment use. Review of 2014 MedCare Operational Manual identified under Routine Maintenance Overview that periodic maintenance was a vital component in keeping mechanical			F0689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
F0689 SS = E	Continued from page 7 lift in safe operating condition and a manufactured checklist was attached in the manual. Equipment that was not properly maintained would create potentially hazardous situations for nursing staff and residents. If, the equipment did not pass the maintenance test, it was to be removed from service. Periodic testing included general visual inspection of the external parts and functions to ensure no adverse damage has occurred. Recommended service of lifts identified lifts had an expected life of 10 years. In addition, the serial number was posted on the lift had identified the month and date when the product was manufactured. The medical director was contacted during survey visit; however, a call was not received back.			F0689			
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess past trauma and implement individualized care plan interventions utilizing a trauma-informed approach for 1 of 2 residents (R3) reviewed who had post-traumatic stress disorder (PTSD) symptoms. Findings include: R3's Minimum Data Set (MDS) assessment dated 4/23/25 indicated R3 had intact cognition, adequate hearing, clear speech, can understand others, adequate hearing, and able to make needs known. R3 was admitted on 1/31/23 with diagnoses of Personality Disorder ((PD) a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems), Suicidal Ideation ((SI) thinking about or planning to harm yourself), Major Depressive Disorder ((MDD) mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Generalized Anxiety Disorder ((GAD) mental			F0699	F699 R3 had a trauma assessment attempted by social services coordinator on 8/20/25 but resident refused to complete the trauma assessment. Social services coordinator documented refusal and will attempt again on 8/21/25. R3 had care plan updated on 7/31/25 to include individual care plan interventions based on Post-Traumatic Stress Disorder (PTSD) diagnosis. Social Services assessment checklist has been updated to include need to complete the trauma assessment and an individualized care plan according to assessment upon admission, quarterly, annually, and with change of condition. Trauma Informed Care and Culturally Competent Care policy and procedure was reviewed and updated on 8/20/2025. All current residents in the facility will have a trauma assessment completed and care plan will be updated to include individual care plan interventions based on assessment by date of compliance. Risk of re-occurrence will be minimized by the Administrator or designee initiating the following: All social work coordinators will be re-educated on the facility policy Trauma Informed Care and Culturally Competent Care by date of completion. Education of the policy was initiated on 8/20/2025. Education included: ensuring all residents are assessed for trauma upon admission, quarterly, annual, and with change of condition and an individualized care plan will be completed based on assessment. Audits will be completed once weekly on 5 random		08/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
F0699 SS = D	Continued from page 8 health condition characterized by persistent and excessive worry about a variety of events or activities), and Post-traumatic Stress Disorder ((PTSD) mental health condition that can develop after experiencing or witnessing a traumatic event). R'3 current medications include hydroxyzine for general anxiety disorder and imipramine for major depressive disorder. R3's care plan dated 2/7/23, identified a potential for altered mood related to PTSD, MDD, GAD, SI, and PD. R3's interventions for altered mood included opportunity to express self, contact family, contact provider, encourage activity participation, medicate as ordered, monitor side effects, monitor changes/declines in mood, and redirect/reorient/reassure as needed. R3's care plan dated 2/7/23, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization. During interview on 7/24/5 at 8:59 a.m., R3 stated the sign on her door was because she does not like loud noises; they scare her. She prefers visitors and staff knock softly so she does not get scared. R3 stated she believes this was due to her past trauma; she just doesn't like loud startling noises. R3 stated facility staff have not asked her about her past trauma, so she is unsure if they know anything. During interview on 7/24/25 at 9:14 a.m., infection preventionist (IP) who was immediately outside resident room, stated she did not believe R3 had a diagnosis of PTSD. IP stated she does not think R3 had any other mental health diagnosis. During interview on 7/24/25 at 9:16 a.m., nursing assistant (NA)-A stated, to her knowledge, the resident does not have a PTSD diagnosis. NA-A stated R3 does not have any PTSD-related triggers. During interview on 7/24/25 at 9:19 a.m., assistant director of nursing (ADON) stated resident does have a diagnosis of PTSD, anxiety, and depression. ADON confirmed R3 does not have a PTSD-specific care plan with related interventions to prevent re-traumatization. ADON confirmed R3 should have a PTSD-specific care plan. During interview on 7/24/25 at 9:29 a.m., director of nursing (DON) and regional consulting registered nurse (RC-RN) confirmed R3's admission diagnosis of PTSD. DON			F0699	Continued from page 8 residents for 3 months to ensure a trauma assessment has been completed and an individualized care plan based on assessment is in place per policy. Audits ongoing until reviewed at QA until determination made is no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: 8/25/25		

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

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
F0699 SS = D	Continued from page 9 and RC-RN confirmed R3 does not have a PTSD-specific care plan with related interventions to prevent re-traumatization. ADON confirmed R3 should have a PTSD-specific care plan. A facility policy titled Trauma Informed Care and Culturally Competent Care dated August 2022, the facility will address the needs of trauma survivors by minimizing triggers and/or re-traumatization by developing individualized trauma-based care plans that address past trauma.		F0699				
F0726 SS = F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by:		F0726	F726 Policy and procedure, Mechanical Lift Inspection Policy and Procedure reviewed and updated on 7/23/2025. Policy and procedure, Lift Machine, Using a Mechanical reviewed and updated on 7/23/2025. Rubber stoppers on the 4-point sling support neck have been installed on all mechanical lifts and sit to stand lifts. “Do not use” tags were purchased for staff to apply to the lifts that need maintenance, and lift will be removed from floor if not in working order. Lift safety checklist has been applied to each lift for staff to review prior to using the lifts. All nursing staff that have not already completed the mandatory training skills fair for transfers in July 2025 will have competency completed by compliance date. Competency included EZ stand transfers, Hoyer lift transfers and lift safety measures. Staff that have not been scheduled to work prior to compliance date will complete competency prior to their next scheduled shift. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All clinical staff (RN's, LPN's, TMA's, and CNA's) will be re-educated on the facility policy, Lifting Machine, Using a Mechanical. The education includes review of entire policy and procedure including ensuring rubber stops are always on before use and how to identify and report lift maintenance concerns. Staff completed a quiz to confirm competency on the policy. Quiz included the following areas: how to identify/report lift maintenance request and how to		08/25/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
F0726 SS = F	Continued from page 10 Based on observation, interview and document review, the facility failed to ensure staff were appropriately trained and educated on how to identify and report mechanical lift maintenance concerns to prevent accidents and hazards. This practice had the potential to affect 11 of 11 residents who were assessed to use the mechanical lifts and stands. Findings include: Review of July 2025 mandatory training skills fair attendance sheet identified 27 of 88 nursing staff had completed the competency checklist. During an observation and interview on 7/21/25 at 1:42 p.m., nursing assistant (NA)-B identified 2 mechanical lifts labeled 31, 32 and 30 a sit to stand lift was missing rubber sling stoppers on the 4-point sling support hook. NA-B identified only a few of the mechanical lifts in the facility had rubber sling stoppers in place and nursing staff was directed to use the mechanical lifts for resident transfers. NA-B acknowledge the rubber sling stopper was to prevent the slings from sliding out of the sling support bar during transfers and to prevent resident falls from the lift, if not properly secured. Further observation on 7/22/25 at 9:22 a.m., identified on wing 3 had 2 mechanical lifts labeled 26, 27 and 28 a sit to stand lift was missing rubber sling stoppers. During an interview on 7/22/25 at 5:30 p.m., licensed practical nurse (LPN)-A confirmed the mechanical lifts did not have rubber sling stoppers in place and verified unawareness the reason for the rubber sling stoppers. Interview on 07/22/25 at 5:34 p.m., with NA-E identified the mechanical lifts was to have rubber stoppers in place and had not seen them on all of the lifts. NA-E identified when he uses a mechanical lift with no rubber stopper in place he would double loop the strap to prevent the sling from sliding off. Interview on 07/23/2025 at 6:54 a.m., with registered nurse (RN)-A and NA-G identified the mechanical lift required 2 nursing staff to assist residents with transfers. Both RN-A and NA-G was unsure of the reason for the rubber sling stoppers. However, NA-G identified the rubber sling stoppers was not important and the lift could still be used to transfer residents.		F0726	Continued from page 10 take a lift out of service. The education on this policy was initiated and competency demonstrated beginning on 7/23/2025 and will be completed by date of compliance. Staff that have not yet been scheduled to work prior to compliance date will complete education prior to their next scheduled shift. 2) Audits will be completed on 5 random nursing department staff members weekly for 3 months to ensure they understand lift safety, including ensuring the rubber stoppers are always in place prior to lift use and ensuring they are aware of how to report maintenance concerns/take lift out of service. Audits ongoing until reviewed at QA until determination made is no longer necessary. 3) Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
F0726 SS = F	Continued from page 11 Interview on 07/23/2025 at 7:04 a.m., with RN-B was unsure of the reason for rubber sling stoppers on the mechanical lift. Interview on 7/23/25 at 10:37 a.m., with director of nursing (DON) identified the facility implemented a performance improvement project (PIP) to identify current training processes and improve onboarding practices and staff knowledge to safely provide quality care to residents. Review of April 2025 facility assessment identified the facility utilized corporate resources to train and hire employees, based on experience and competency to ensure continuity of care across all departments, when needed. The facility was to provide information and training that was consistent with standards of practice and facility management was to meet to consider standards of care to ensure nursing staff was knowledgeable to safely care for residents. Education for nursing staff was vital in providing the highest level of care to residents and was to include Client Mobility: Exercise and Ambulation, Lifting and Safe Transfers, Positioning and Range of motion and Minnesota Safe Patient Handling, upon hire. Ongoing annual training of nursing staff was to include Accident prevention and safety measures by Occupational Safety and Health Administration (OSHA). In addition, the medical director was responsible of resident care policies and procedures and was an active participant of all staff education meetings. Interview on 7/23/2025 4:40 p.m., the administrator was hired March 2025 and was unsure if the facility had reached out to the mechanical lift manufacturer to provide a mechanical service part evaluation on the lifts. She was aware the facility had a monthly checklist for routine maintenance to be completed on all lifts implemented by the maintenance director. However, she had no knowledge the facility had an older lift, not routinely checked for maintenance and was in service on the units. The facility held a mandatory skills training in July 2025 for nursing staff to be educated on the mechanical lifts, however, she identified nursing staff could return to work and continue to transfer residents with the mechanical lifts, even though the mandatory training was not completed for all employees. She acknowledged, it would be difficult for nursing staff to identify and voice maintenance concerns when they have not received appropriate training on equipment use. Review of revised July 2025 Lifting Machine, Using a Mechanical policy identified the nursing staff was to		F0726				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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)	
F0726 SS = F		Continued from page 12 demonstrate competency to ensure safe lifting practices when using the mechanical device in the facility. Review of revised July 2025 General Orientation Policy for Staff identified nursing staff was to receive a comprehensive orientation to promote regulatory compliance and enhance resident safety. All employees, regardless of their role or classification was to participate in a structured orientation program before assuming independent responsibilities when caring for residents.		F0726			
F0880 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 §483.71 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 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;		F0880		F880 Policy and procedure Communicable/Contagious Disease, Employee Policy and Procedure was reviewed and updated on 8/18/25. Infection Preventionist was reeducated on Communicable/Contagious Disease, Employee policy and procedure on 8/19/25. Education included ensuring the employee illness tracking form is completed fully, and ensuring IP is communicating with employee and employee's direct supervisor to ensure return to work date-based on symptoms resolving. Illness communication form was created for supervisors to complete and give IP for employee illness notification. This form will assist the IP in communication with the employee and employee's direct supervisor. Facility's morning meeting agenda updated to include section to ensure IP obtained illness communication forms from department managers. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: All department managers will be re-educated on the facility policy Communication/Contagious Disease, Employee by date of completion. Education of the policy was initiated on 8/19/2025. Education included: ensuring illness communication form is completed and given to IP to ensure timely communication with employee and employee's supervisor on return-to-work date. Audits will be completed on 5 random employee illnesses weekly for 3 months to ensure that required employee illness tracking is completed, including return to work date for employee illness based on symptoms resolving. Audits ongoing until reviewed at QA until determination	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
F0880 SS = D	Continued from page 13 (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 interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employees would be able to return to work after an illness, dependent upon their symptoms for 2 of 3 sampled staff (certified nursing assistant (NA)-Y and dietary aide (DA)-A). This had the potential to affect all 50 residents, staff and visitors. Findings include: Review of Employee Illness logs from May through July 2025 identified the following areas of documentation:		F0880	Continued from page 13 made is no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
F0880 SS = D	Continued from page 14 department, employee name, job title, symptom onset, illness reported, last shift worked, resolution date, return to work, specimen source, and treatment results. However, the facility did not accurately complete the logs to ensure all necessary information was monitored or identified how staff were cleared to return to work. Review of Centers for Disease Control (CDC) article, Norovirus, located at https://www.cdc.gov/norovirus/about/index.html, identified Norovirus is a contagious virus that spreads through direct contact with another person. Symptoms develop 12 to 48 hours after being exposed to norovirus. Prevention was to wash your hands, often, clean and disinfect contaminated surfaces and stay home when sick for 2 days after symptoms stop. Symptoms improve after 1 to 3 days, however, there is no treatment to alleviate norovirus symptoms. Review of the Centers for Disease Control (CDC) article, Clinical Guidance for Group A Streptococcal Pharyngitis, located at https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html, identified Strep is spread through close contact with another person. Crowded settings can increase the risk for spreading the bacteria. Treatment with an appropriate antibiotic for 12 hours or longer limits the person's ability to transmit Strep. Persons infected should stay home from work until both conditions are met: 1) They are without fever. 2) At least 12-24 hours after starting an appropriate antibiotic. Review of June 2025, employee illness log identified DA-A was noted to have called in to work with symptoms of nausea and an upset stomach related to an unknown gastro-intestinal (GI) illness on 6/13/25. Review of DA-A timesheet identified DA-A had worked on 6/13/25 from 7:02 a.m. to 7:12 a.m., for a total of 15 minutes. The log further identified DA-A worked in the kitchen and rarely had exposure to residents. Review of June 2025, employee illness log identified NA-Y was noted to have called in to work with symptoms of sore throat on 6/20/25.			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
F0880 SS = D	Continued from page 15 Review of NA-Y timesheet identified NA-Y had worked on 6/20/25 from 8:00 a.m. to 10:45 a.m., for a total of 2.75 hours. The log identified NA-Y was found positive with strep throat. NA-Y returned to work on 6/25/25. Review of June 2025, resident infection log identified no residents with outbreak of strep or GI illnesses. Review of July 2025, employee illness log identified NA-Y was noted to have called in to work with symptoms of diarrhea on 7/07/25. Review of NA-Y timesheet identified NA-Y had worked on 7/07/25 from 4:06 p.m. to 10:51 p.m. The log further identified NA-Y was on break for one hour with symptoms of diarrhea and returned back to work the same day to finish her shift. Overall, there was no mention when DA-A and NA-Y symptoms resolved prior to returning to work. Review of July 2025, resident infection log identified no resident with GI illnesses. Interview on 7/25/25 at 08:54 a.m., with registered nurse (RN)-C identified her process to track employee illnesses was to receive a copy of each departments staff call-ins, review and identify staff who reported sick and to and discuss at the facility's morning meetings. RN-C was to call those employees who was sick, identify the illnesses reported and determine if further evaluation was needed, depending on the employee's symptoms and risk of transmission. RN-C identified both DA-A and NA-Y lacked appropriate tracking and surveillance of DA-A and NA-Y illnesses to determine if DA-A and NA-Y was appropriate to return back to work. Interview on 7/25/25 at 0:29 a.m., with director of nursing (DON) expectations was for the infection preventionist (IP) or designee, to track, monitor and			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/25/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
F0880 SS = D	Continued from page 16 identify when employee's symptoms resolved and when it was appropriate for employees to return to work. Review of December 2024, Communicable/Contagious Disease, Employee policy identified facility staff who was active with communicable infections, was not to be in contact with residents, resident environment, residents care items and equipment until they were no longer contagious. The IP was to oversee employee health practices, including work restrictions and return to work criteria. In addition, employees was responsible to report suspected or confirmed infections with communicable or infectious disease to their supervisor upon onset and/or prior to reporting to their scheduled shifts. Review of April 2025, Facility assessment identified the facility's infection prevention department was to implement protocols to execute and ensure accurate tracking and mapping of the spread of infections and complete screenings to identify when staff was a potential transmitter of infections and/or communicable diseases.		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/22/2025. At the time of this survey, SACRED HEART CARE CENTER was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			08/25/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. SACRED HEART CARE CENTER is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 with partial basement and was determined to be of Type II(111) construction. In 1997, addition was constructed with partial basement and was determined to be of Type II(111) construction. In 2007, and addition of four rooms were added to the 300 wing of the building and was determined to be of Type II (111) construction. 2-hr fire rated wall(s) separate the Nursing Home from Adult Day Care and Assisted Living Commons. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an		K0000				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
K0000	Continued from page 2 automatic sprinkler system 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. The facility has a capacity of 59 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:		K0000				
K0291 SS = F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9, 7.9.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/22/2025 between 09:00 AM and 12:00 PM, it was revealed by review of available documentation that no documentation was presented to confirm that 90 minute annual testing of emergency lighting had been completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0291	Annual 90-minute light test will be completed by completion date of 8/25/25. Added to preventative maintenance program to be scheduled annually during the month of August.		08/25/2025	
K0293 SS = D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING		K0293	Electrician rewired exit sign in Chapel on 8/11/25. Monthly inspection of exit signs added to preventative maintenance checklist. Will report findings to QA and safety committee.		08/25/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
K0293 SS = D	Continued from page 3 Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly maintain, test, and inspect exit signage per NFPA 101 (2012 edition), section(s) 19.2.10, 7.10, 7.10.1.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/22/2025 at 11:00 AM, it was revealed by observation that the exit sign located in the Chapel was not illuminated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0293				
K0345 SS = D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to conduct fire alarm system testing and maintenance per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 17.14.5. This deficient finding could have an isolated impact on the residents within the facility.		K0345	Currently communicating with vendors to schedule fire alarm sensitivity testing as soon as possible. Will schedule into preventative maintenance program to be completed annually.		08/25/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
K0345 SS = D	Continued from page 4 Findings include: On 07/22/2025 between 09:00 AM and 12:00 PM, it was revealed by review of available documentation that most current fire alarm sensitivity documentation of record was completed in 2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0345				
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.2(5). This deficient finding could have an isolated impact on the residents within the facility. Findings include:		K0353	Kitchen/Dishwashing sprinkler heads debris was cleaned off on 7/23/25. Quarterly inspections have been added to the preventative maintenance checklist. Will report findings to QA and safety committee.		08/25/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
K0353 SS = D	Continued from page 5 On 07/22/2025 at 11:15 AM, it was revealed by observation that sprinkler head(s) in the Kitchen / Dishwashing Area exhibited signs of debris loading. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0353				
K0374 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/22/2025 at 11:15 AM, it was revealed by observation that smoke barrier door assembly (W2-01) exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. 2. On 07/22/2025 at 11:15 AM, it was revealed by observation that smoke barrier door assembly (W3-01) exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified these deficient findings at the time of discovery.		K0374	Astragal ordered on 8/18/25 for both doors W2-01 and W3-01. Astragal will be installed by completion date of 8/25/25.		08/25/2025	
K0511	Utilities - Gas and Electric		K0511	W3 corridor electrical panel was locked on 7/22/25 W3		08/25/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
K0511 SS = F	Continued from page 6 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(F), 110.27(A)(1) These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/22/2025 at 11:20 AM, it was revealed by observation that the electrical panel in the W3 corridor was found to be unsecured and readily accessible to unqualified individuals. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0511	Continued from page 6 electrical panel will be added to daily rounds checklist. Maintenance director will randomly audit W3 electrical panel 3 times per week for 3 months. Findings will be brought to QA and safety committee.		
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			K0712	Fire drills have been scheduled by the Environmental Services Director for the year to ensure each shift will have a fire drill at least quarterly. Completed drills will be reported monthly to QA.		08/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
K0712 SS = F	Continued from page 7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/22/2025 between 09:00 AM and 12:00 PM, it was revealed by review of available documentation that no documentation was presented to confirm that fire drill(s) had been conducted for 1st Shift – Q4 or 3rd Shift – Q4. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0712			
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.4.5, and NFPA 80 (2010 edition), sections 5.2.1. These deficient findings could have a widespread impact on			K0761	Door assembly was repaired on 7/24/25 to meet compliance of an air-gap less than 1/8 inch. All fire doors will be inspected monthly to ensure compliance of an air-gap less than 1/8 inch. Findings will be brought to QA and safety committee.		08/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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	
K0761 SS = F	Continued from page 8 the residents within the facility. Findings include: On 07/22/2025 at 11:20 AM, it was revealed by observation that that the fire door assembly (B-03) exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0761				
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have a isolated impact on the residents within the facility. Findings include:		K0920	Extension cord removed from scheduler's office on 7/23/25. Education was provided to staff at All Staff Meeting on 8/7/25 that extension cords are not acceptable to use in the facility. Added monthly preventative maintenance inspection for extension cords of all resident rooms and offices. Will bring findings to QA and safety committee.		08/25/2025	

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2025	
NAME OF PROVIDER OR SUPPLIER Sacred Heart Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST , AUSTIN, Minnesota, 55912			
(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
K0920 SS = D Bldg. 01	Continued from page 9 On 07/22/2025 at 11:25 AM, it was revealed by observation that in the Schedulers Office, and extension cord was found providing power to a relocatable power tap. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0920			