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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: G7KS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00640

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245341**
2.STATE VENDOR OR MEDICAID NO.
(L2) **857698100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING**
(L4) **425 N ELM STREET**
(L5) **SAUK CENTRE, MN** (L6) **56378**

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) **12/01/2012**

6. DATE OF SURVEY **07/19/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (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
	60			
(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:
Brenda Fischer, Unit Supervisor — 07/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 07/24/2018 (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
08/01/1986
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/18/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245341 July 24, 2018

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

Dear Mr. Christianson:

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 July 11, 2018 the above facility is certified for:

38 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 38 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.

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 24, 2018

Mr. Delano Christianson, Administrator
CentraCare Health System - Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

RE: Project Number S5341027

Dear Mr. Christianson:

On June 20, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 25, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 26, 2018

This was based on the deficiencies cited by this Department for a standard survey completed on June 7, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 19, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 12, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 11, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 7, 2018, as of July 11, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 11, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of June 20, 2018:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 26, 2018 be rescinded as of July 11, 2018. (42 CFR 488.417 (b))

In our letter of June 20, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from

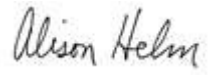
conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 26, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 11, 2018 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

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

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(L4) **425 N ELM STREET**
(L5) **SAUK CENTRE, MN** (L6) **56378**

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) **12/01/2012**

6. DATE OF SURVEY **06/07/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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13.Total Certified Beds **60** (L17)

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(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:
Austin Fry, HFE NE II — 07/05/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 07/18/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(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
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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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 20, 2018

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

RE: Project Number S5341027

Dear Mr. Christianson:

On June 7, 2018, 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby significant corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

Appeal Rights – the facility rights to appeal imposed remedies; 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), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective June 25, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 26, 2018

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 26, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 26, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 26, 2018 . This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

- 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 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 September 7, 2018 (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 December 7, 2018 (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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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

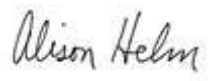
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING _____ B. WING _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for Centers for Medicare and Medicaid (CMS) Appendix Z Emergency Preparedness Requirements, was conducted from 6/4/18 to 6/7/18, during a recertification survey. The facility is was found to NOT be in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address in its emergency preparedness plan (EPP) the patient/client population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in case of emergency. This had the potential to affect all 50 of 50 current	E 007	An Emergency Preparedness Plan will be adapted from other CentraCare Health Facilities, and this plan will address the Patient/Resident/Client population. Specific needs and Services to CentraCare Health Sauk Centre will be modified and included within this plan and references to existing emergency contracts and policies, as well as	7/11/18

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

Electronically Signed | 06/28/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING _____ B. WING _____	06/07/2018

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

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E 007	Continued From page 1 residents of the facility. Findings include: A facility document, Emergency Management Program Description, revised 3/18, together with its complementary policies/procedures with various revision dates, were identified as the facility's EPP. There was nothing in the plan that addressed resident population, including, persons at-risk, the type of services the facility has and the ability to provide these in an emergency, continuity of operations, including authority and succession plans during an emergency. During interview on 6/7/18, at 10:12 a.m., the director of nursing stated the facility risk assessment described the resident population served, but was not part of of the EPP documents. The manager of facilities and safety (MFS) stated the policy as presented lacked a plan for delegation of authority, and information on what services the facility would continue during emergency.	E 007	continuity of operations during an emergency. This plan will refer to the Healthcare Incident Command System (HICS) for delegation of authority and chain of command in an emergency. The Emergency Preparedness Plan and its contracts and policies will be reviewed annually, and necessary changes made and approved by the CentraCare Health Sauk Centre Emergency Preparedness and Safety Committees and Safety Director Keith Johnson.	
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact	E 009		7/11/18

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E 009	Continued From page 2 such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in their emergency plan. This had the potential to affect all 50 current residents in the facility. Findings include: A facility document, Emergency Management Program Description, revised 3/18, together with its complementary policies/procedures with various revision dates, as the facility's EPP did	E 009	CentraCare Health Sauk Centre is a member of the Central Minnesota Healthcare Preparedness Coalition, a collection of 19 Hospitals, 1 Tribal Band, and Public Health Departments in 14 counties in Minnesota. A memoranda of understanding (MOU) exists within this group, in which it□s members acknowledge their willingness to provide assistance of fellow members in the event it is needed during an emergency. Information concerning this coalition, as well as by-laws, policies, and the MOU will be kept within the Safety/Emergency Preparedness manual in hard copy in the CentraCare Health Sauk Centre Facilities Manager□s office as well as online for all Employees to view.	

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E 009	Continued From page 3 not identify any process for collaboration with local, tribal, regional, state, and federal emergency preparedness officials. There were no efforts identified to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials, when applicable, of its participation in collaborative and cooperative planning efforts in their emergency plan. During interview on 6/7/18, at 10:16 a.m., the manager of facilities and safety (MFS) stated the facility was part of a health care coalition, and was sure they had MOUs (memoranda of understanding) with various levels of government regarding emergency planing. The MFS stated he could not find documentation to support the requirement.	E 009	CentraCare Health Sauk Centre Safety Director Keith Johnson will attend Coalition meetings and will report developments and Coalition information to the CentraCare Health Safety Committee monthly. The MOU will be reviewed annually and updated as needed.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the	E 015		7/11/18

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E 015	Continued From page 4 following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop in its emergency preparedness plan (EPP) policies and procedures which included provision of maintenance for needs of residents and staff whether they evacuate or shelter in place during an emergency, including, but not limited to food,	E 015	Policies and procedures will be developed and implemented covering subsistence needs such as food, water, and pharmaceutical supplies for Residents, Patients and Staff. Operating procedures for Standby Generators serving the Hospital and Nursing Home	

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E 015	Continued From page 5 water and pharmaceuticals; alternate energy sources to protect residents, and for safe storage of provisions, emergency lighting, fire detection and waste disposal. This had the potential to affect all 50 current residents of the facility at the time of the survey. Findings include: A facility document, Emergency Management Program Description, revised 3/18, together with its complementary policies/procedures with various revision dates, identified there was no policy/plan that identified what supplies and resources were needed if the facility implemented shelter in place or evacuation plan as part of the facility's EPP. During interview on 6/7/18, at 10:33 a.m., the director of nursing (DON) and manager of facilities and safety (MFS) stated there was no specific policy about sheltering in place and how the residents provision would be met during potential emergency situations. The MFS stated after looking through various files "that may not be in our policy."	E 015	energy, temperature, lighting, fire alarm system detection, extinguishing needs will be in this policy, as well as how these needs will be met should the Generators fail. Sewage and waste disposal will be addressed as well. These policies and procedures will address these needs for sheltering in place, or evacuation of the Facility. Policies and procedures mentioned above will be reviewed annually and necessary changes made and approved by the CentraCare Health Emergency Preparedness and Safety Committees and CentraCare Health Sauk Centre Safety Director Keith Johnson.	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must	E 022		7/11/18

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E 022	Continued From page 6 address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and include in its emergency preparedness plan (EPP) policies and procedures for sheltering in place for residents, staff and volunteers in the facility in the event of an emergency. This had the potential to affect all 50 residents currently resided in the facility at the time of the survey. Findings include: A facility document, Emergency Management Program Description, revised 3/18, together with its complementary policies/procedures with various revision dates, identified there was no policy or plan about sheltering in place and when this would occur for their patients, staff, and volunteers who remained in the facility as part of the facility's EPP. During interview on 6/7/18, at 10:36 a.m., the	E 022	Procedures will be created and implemented for Sheltering in Place Residents, Patients, Volunteers and Staff in the event of an emergency event, and these will be included in the Emergency Preparedness Plan. The Emergency Preparedness Plan will be reviewed annually, and necessary changes made and approved by the CentraCare Health Sauk Centre Emergency Preparedness and Safety Committees and CentraCare Health Sauk Centre Safety Director Keith Johnson.	

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E 022	Continued From page 7 director of nursing was not aware of any policy about sheltering in place. The manager of facilities and safety (MFS) stated "I 'm sure we must have that" but was not able to locate a policy regarding sheltering in place.	E 022		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop in its emergency preparedness plan (EPP) policies and procedures addressing the screening and use of volunteers who may be used in emergency staffing	E 024	We are developing a policy for volunteers. Volunteers who would assist in an emergency event would be required to	7/11/18

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E 024	Continued From page 8 strategies. This had the potential to affect all 50 current residents of the facility. Findings include: A facility document, Emergency Management Program Description, revised 3/18, together with its complementary policies/procedures with various revision dates, did not identify how the facility would screen and use volunteers in an emergency as part of the facility's EPP. During interview on 6/7/18, at 10:40 a.m., the manager of facilities and safety (MFS) stated the policies did not include anything about screening people who may be helping out in an emergency situation. The MFS stated "We don't have that."	E 024	complete the CentraCare Health Volunteer screening process. This process involves a criminal background check, as well as vaccination and Mantoux screening. CentraCare Health Sauk Centre would contact other CentraCare Health Facilities, and the Central Minnesota Healthcare Coalition for staff augmentation if needed during an emergency. These plans and policies will be reviewed annually with necessary changes made and approved by the CentraCare Health Emergency Preparedness and Safety Committees and CentraCare Health Sauk Centre Safety Director Keith Johnson.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management	E 026		7/11/18

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E 026	Continued From page 9 officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop in its emergency preparedness plan (EPP) policies and procedures identifying the facility's roll in providing care and treatment to residents at an alternate care site under an 1135 waiver. This had the potential to affect all 50 current resident in the facility. Findings include: A facility document, Emergency Management Program Description, revised 3/18, together with its complementary policies/procedures with various revision dates, the policy did not identify the facility's roll in providing care and treatment to residents at an alternate site, under the 1135 waiver as part of the facility's EPP. During interview on 6/7/18, at 10:42 a.m., the manager of facilities and safety (MFS) stated the policies did talk about providing care at alternate locations. The MFS stated "We do not have that in any policy."	E 026	A plan for providing care and treatment to Residents/Patients at an alternative care site will be developed to comply with a waiver issued by Secretary. This plan will be reviewed annually, and necessary changes made and approved by the CentraCare Health Emergency Preparedness and Safety Committees and CentraCare Health Sauk Centre Safety Director Keith Johnson.	
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan	E 029		7/11/18

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E 029	Continued From page 10 that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop in its emergency preparedness plan (EPP) a written emergency communication plan that contained a description of how the facility will coordinate patient care within the facility, across healthcare providers, and with state and local public health departments in order to protect the health and safety of their patients/residents. This had the potential to affect all 50 current residents in the facility. Findings include: A facility document, Emergency Management Program Description, revised 3/18, together with its complementary policies/procedures with various revision dates, identified that multiple areas of the communication plan and policy were missing as part of the facility's EPP. The areas that were not identified included: Development of a communication plan (E29) - develop and maintain an emergency preparedness communication plan that complies with federal, state and local laws. Names and Contact Information (E30) - the communication plan includes; names and contact information for staff, resident's physicians, other long term care facilities and volunteers. Primary/Alternate Means of Communication	E 029	A communications plan will be included within the Emergency Preparedness Plan which will address the Following: -Staff contact information (names, telephone numbers, addresses) -Resident Physicians (names, telephone numbers, addresses) -Volunteers (names, telephone numbers, addresses) -Other Facilities and Public Health Organizations (as listed as participants in the Central Minnesota Preparedness Coalition MOU) -Sharing Resident/Patient information and medical documentation under the authority of CentraCare Health Sauk Centre with other health providers to maintain the continuity of care. -A method of providing information about the Facility□s occupancy, needs, and its ability provide assistance to the Authority Having Jurisdiction. Call and contact information lists will be checked and updated as necessary quarterly throughout the year. Plans regarding providing Resident/Patient information and medical documentation to other Healthcare Facilities to ensure continuity of care, as well as methods of providing information about CentraCare Health Sauk Centre□s occupancy, needs, and its ability to provide assistance to the	

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E 029	Continued From page 11 (E32) - primary and alternate means for communicating with facility staff, and federal, state, tribal, regional, and local emergency management agencies. Methods for Sharing Information (E34) - a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health providers to maintain the continuity of care. Sharing Information on Occupancy and Needs (E34) - a means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Family Notification (E35) - a method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents and their families or representatives. On 6/7/18, at 10:47 a.m., the manager of facilities and safety (MFS) and director of nursing (DON) were interviewed regarding the facility's emergency plan and the communication component. The MFS and DON acknowledged the facility had not developed a communication plan. The DON stated they knew where the information was currently located, but had not compiled the needed documents and information into the plan, "that will still need to be done." The MFS agreed with the DON. No additional information was provided by the	E 029	AHJ will be reviewed annually by the CentraCare Health Sauk Centre Emergency Preparedness and Safety Committees and CentraCare Health Sauk Centre Safety Director Keith Johnson.	

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E 029	Continued From page 12 facility.	E 029		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their	E 037		7/11/18

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	245341	A. BUILDING _____ B. WING _____	06/07/2018

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

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expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in

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E 037	Continued From page 14 case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 15 procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an emergency preparedness training program in accordance with 42 CFR, Section 483.73 (d)(1). This had the potential to affect all 50 current residents in the facility at the time of the survey. Findings include: A facility document, Emergency Management Program Description, revised 3/18, together with its complementary policies/procedures with various revision dates, were reviewed. There was no evidence the facility staff were trained or received other information unique to the facility's EPP. When interviewed on 6/6/16 at 10:10 a.m. nursing assistant (NA)-C stated the facility completed drills, like moving resident of their room, but could not recall any specific emergency plan training.	E 037	Initial training in Emergency Preparedness will be conducted with new Employees and Volunteers prior to employment at CentraCare Health Sauk Centre. Thereafter Emergency Drills will be conducted, with Staff reaction monitored and coaching done if required. In addition to this, Computer Based Training in emergency actions will be required annually of all Staff at CentraCare Health Sauk Centre. Completion of this training will become a part of the Employee□s Education Record. Training plans will be reviewed and changes as necessary will be made annually and approved by the CentraCare Health Sauk Centre Emergency Preparedness and Safety Committees, CentraCare Health Education Department, and CentraCare Health Sauk Centre Safety Director Keith Johnson.	

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E 037	Continued From page 16 When interviewed on 6/6/16 at 10: licensed practical nurse (LPN)-B stated she did not think there was any facility wide emergency training. LPN-A stated there were procedures for evacuation in case of fire, or if a resident eloped, but added she could not recall any specific training for a bigger plan. During interview on 6/7/18, at 11:02 a.m., the manager of facilities and safety (MFS) stated there was "no formal" schedule of training. The MFS stated there was the annual tornado drill and other evacuation drills, and testing of backup equipment, but no specific training for the emergency plan. "I don't think we have done that."	E 037		
F 000	INITIAL COMMENTS On 6/4/18 through 6/7/18, a standard survey was completed at your facility by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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		

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F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident personal trust fund account(s) were insured with adequate surety bond coverage (a contract or promise by a surety or guarantor to pay a certain amount if a second party fails to meet the obligation) to cover the total account balance. This had potential to affect 48 of 48 residents identified to have an account with a positive balance. Findings include: A Centracare Health - Sauk Centre Trust - Current Account Balance listing printed 6/6/18, identified 48 residents had current trust fund accounts with a positive balance. The total amount of these accounts was recorded as $10,501.85. During the recertification survey, evidence was requested and provided to demonstrate an Surety bond was in place for these account(s). A Certificate of Liability Insurance dated 6/6/18, identified the facility had a Surety bond in place, however, only for a listed amount of $10,000. When interviewed on 6/7/18, at 8:20 a.m. licensed social worker (LSW)-A stated herself and the business office manager (BOM) were responsible to manage the resident' trust fund	F 570	Corrective Action: Immediately after being made aware the surety bond was not enough to cover the total amount of the residents' trust fund accounts, the surety bond was increased to $20,000 to assure the security of all personal funds of the residents deposited with the facility. Identification of others: Any residents that has funds deposited in the residents trust fund account is listed on the resident fund account balance statement. Measures put into place: A policy was written, "Resident Fund Surety Bond", to ensure residents funds are available at anytime a resident and/or the resident representative should request to withdraw funds. Monitoring: The business office or designated person will be given a resident fund account balance update monthly and at the time of renewal of surety bond for certificate of liability insurance. The designated person will verify the fund account balance is adequate to cover all resident funds and	7/11/18

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F 570	Continued From page 18 accounts. LSW-A reviewed the Surety bond provided and stated it was not enough to cover the total amount of resident' trust fund accounts ($10,501.85). LSW-A stated she would update the administrator and have it adjusted, further adding it was important to ensure resident' accounts were adequately insured so residents' can receive their funds should anything happen to the facility financially. A facility policy on Surety bond coverage was not provided.	F 570	petty cash funds in the facility. An updated balance will be made available to the administrator. These findings will be reported to the Quarterly QA meeting beginning 7/11/2018.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		7/11/18

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F 580	Continued From page 19 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the responsible party was notified timely of therapy being initiated, and subsequent changes in the diet for 1 of 2 residents (R13) reviewed for nutrition. Findings include: R13's quarterly Minimum Data Set (MDS) dated 3/16/18, identified R13 had severe cognitive impairment and did not consume a mechanically altered diet. R13's Admission Record printed 6/6/18, identified R13's family member (FM)-A as	F 580	Corrective Action: Licensed staff were re-educated at the staff meeting on 6/28/2018 that the facility must immediately inform the resident and/or the resident representative if there is a significant change or a need to alter treatment significantly. A note was also placed in the communication book. Identification of others: Reviewed all orders received for the month of June to see if notification was made to the resident and/or the resident	

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F 580	Continued From page 20 his primary emergency contact and, "Care Conference Person." During interview on 6/5/18, at 1:30 p.m. FM-A stated R13 had been consuming a pureed diet for the past several weeks now, however, she had never been called and updated as to why it was being done. FM-A expressed she "still really didn't know why he went to the pureed [food]," and added she found out R13 had been seen by speech therapy and started on this diet only after visiting her other relative and seeing it being served to him (R13). FM-A stated she would have liked to have been updated when these changes were made versus having it be "hear say" when visiting later on. R13's progress notes were reviewed and identified the following entries: On 4/28/18, R13 was recorded as "...frequently pocketing food," and a three day trial of pureed food was requested. A speech therapy evaluation was placed on the calendar for 4/30/18. On 4/30/18, a physician order was requested and received for a speech therapy evaluation. Speech Language Pathologist (SLP)-A completed the evaluation and an order was provided to change R13's diet from regular to pureed with thin liquids. R13's medical record was reviewed and lacked any evidence FM-A had been updated to R13's pocketing food(s), the initiation of speech therapy, nor his change in diet from regular consistency to pureed. When interviewed on 6/6/18, at 1:16 p.m.	F 580	representative regarding any significant change in treatment. Measures put into place: Reviewed the policy, "Change in Condition - Long Term Care", for any needed changes. No changes were needed. Monitoring: The DON/ADON/Designee will monitor the day board for orders of significant changes or a need to alter treatment significantly to see if notification was made to the resident and/or resident representative. Will monitor 1 day per week for 2 months, then 2 times per month for 2 months, then 1 time per month for 2 months, then as needed. If notification has not been made regarding a significant changes or a need to alter treatment significantly, the DON/ADON/Designee will do education with the staff involved. These findings will be reported to Quarterly QA meeting beginning 7/11/2018.	

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F 580	Continued From page 21 registered nurse (RN)-A stated R13's diet had been changed on 4/30/18, due to him pocketing his food in his mouth. RN-A explained FM-A was the responsible party for R13 and "does everything for him," adding she "hopefully" was called and updated when these changes were made. RN-A reviewed the medical record and stated it lacked evidence FM-A had been updated with these changes and added, "If you don't document it, it wasn't done." A facility Change In Condition - Long Term Care policy dated 10/2017, identified a purpose to respond and inform the medical provider, resident and their representative of abrupt changes in a resident's condition. The policy directed to "immediately" consult with a resident and/or their representative if their is a significant change or a need to alter treatment significantly including, "a need to discontinue or change an existing form of treatment ... or to commence a new form of treatment."	F 580		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		7/11/18

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and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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F 623	Continued From page 24 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the ombudsman of a hospital transfer for 1 of 2 residents (R35) reviewed for facility initiated transfers. Findings include: R35's annual Minimum Data Set (MDS) dated 4/20/18, identified R35 was cognitively intact. R35's progress note (s) identified: -4/27/18, at 11:53 a.m. R35 was transferred to the hospital via ambulance to the hospital. -5/2/18, at 2:43 p.m. R35 was hospitalized from 4/27/18, through 5/2/18, for severe sepsis (potentially life threatening infection) from acute cholecystits (inflammation of the gallbladder). During interview on 6/6/18, at 2:24 p.m. licensed social worker (LSW)-A stated an individual form was faxed to the ombudsman office when a resident was transferred to the hospital. The form was located in the resident medical record. R35's medical record lacked notification to the ombudsman regarding R35's hospital transfer. An e-mail received on 6/7/18, at 10:50 a.m. from the ombudsman (O)-A office, identified the ombudsman office was not notified of R35's hospital on 4/27/18. During follow up interview on 6/7/18, at 11:13 a.m. LSW-A stated the facility never notified O-A	F 623	Corrective Action: Licensed staff were educated at the staff meeting on 6/28/2018 that before a facility transfers or discharges a resident, the facility must notify the resident and the resident representative of the transfer or discharge and the reason for the move in writing. Social Services will then send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Identification of others: Will go back to December to see who was transferred or discharged and if the necessary paperwork was completed. Measure put into place: Social Services updated the "Notice of Transfer or Discharge" form to include where copies of the form are sent to. Social Services was added to the email group that receives the Nursing Home Daily Census report that is emailed out daily with updates of admissions/transfers/discharges/deaths. Monitoring: Social Services/Designee will check the Nursing Home Daily Census report daily for transfers/discharges. Social services/designee will monitor the "Notice of Transfer" documentation weekly to be sure that the resident and/or resident representative have been notified. A log	

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F 623	Continued From page 25 of R35's transfer to the hospital on 4/27/18. It was important to the notify the ombudsman regarding hospital transfers, so if there were any resident issues with returning from the hospital the ombudsman could help facilitate the resident with their rights. The facility policy Discharge- Involuntary Discharge of resident - Long term Care dated 12/17, identified before a facility transferred or discharged a resident a copy of the the transfer/ discharge would be provided to a representative of the office of the State Long- Term Care ombudsman.	F 623	will be kept on notifications sent including the Ombudsman. These findings will be reported to the Quarterly QA meeting beginning 7/11/2018.	
F 689 SS=G	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 1 of 1 resident (R36) who used a mechanical standing lift and needed assistance for transfers was left alone at the edge of the bed while staff retrieved a mechanical lift. R36 fell resulting in a fractured right humerus (long bone of upper arm) and facial bruising that required medical attention. Staff subsequently placed R36 back into bed without first being evaluated and did not report this fall until 24 hours after the incident occurred. These	F 689	Corrective Action: The nursing assistant (NA) involved in the accident was removed from caring for the resident on 5/12/18. On 5/13/18 the NA was removed from work and sent home after reporting what had happened with the resident and how the resident sustained her injuries. The NA was not allowed to return to work until after meeting with the DON. The DON and ADON met with the NA on 5/14/18 where	7/11/18

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F 689	Continued From page 26 actions resulted in actual harm for R36 who suffered a right humerus fracture and facial bruising while left unattended at the bedside. Findings include: R36's diagnoses, as identified on the Admission Record printed 6/7/18, included Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 4/20/18, indicated R36 was severely, cognitively impaired. The MDS indicated R36 was dependent upon staff for transfers, and did not walk. The MDS indicated with transfers R36 was not steady, and only to stabilize with human assistance. The MDS further indicated during sit-to-stand transfers (for example from sitting on bed to standing) or surface to surface transfers (for example from bed to wheel chair seat), R36 was unsteady and required human assistance. During observation on 6/5/18, at 6:04 p.m.. nursing assistant (NA)-C and NA-F began evening cares for R36. NA-C placed the lift sling tabs onto the metal arms of the lift, then NA-F activated the arm which lifted R36 from the wheel chair, and NA-C guided R36 into bed as the lift arm lowered. NA-C and NA-F rolled R36 side to side to remove the lift sling from underneath R36. During the movement back and forth, R36 had verbalizations of pain. NA-C and NA-F began to remove R36's clothing and shoulder to wash under R36's arms and upper body. As NA-C and NA-F removed the Velcro from the immobilizer, all the while R36 was grimacing. When NA-F took the immobilizer off, R36 began to cry out in pain, and several times cried and verbalized "Ow" in pain. During the provision of cares, NA-C and NA-F talked to R36 continuously, giving	F 689	the NA reported what had happened. It was determined that the NA would received a written warning and 3-days suspension without pay. The NA was re-educated on proper use of the lifts and to not moving a resident after a fall until the nurse has been able to assess the resident. Moving a resident could result in more injuries. The NA, along with the other staff, attended a skills fair on 6/12/18 or 6/14/18 that included competency of using a mechanical lift. Identification of others: Reviewed all residents who transfer with a mechanical lift. Measure put into place: Educated all staff at the staff meeting on 6/28/2018 of the importance of having the mechanical lift within reach, or to lay a resident down if you need to step away to get the lift, or to call for someone to assist you. Monitoring: The DON/ADON/Designated licensed staff will monitor the NA involved in the accident effective immediately for 2 weeks with all transfers involving a mechanical lift, then 2 days per week for 2 months, then 1 day per week for 2 months, then 2 times per month for 2 months, then 1 time per month for 2 months, then as needed. If it is noted that NA is not following the policy, the DON/ADON/Designee will do education with the NA. These findings will be reported to Quarterly QA meeting beginning 7/11/2018.	

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encouragement and frequently stated "we're almost finished." R36's expression of pain stopped when NA-C and NA-F stopped moving R36. NA-C and NA-F reported R36 had a humerus fracture from a recent fall.

When interviewed on 6/5/18, at 7:12 p.m., NA-C stated R36 definitely has pain when doing the HS (evening) cares. NA-C stated you try to be a gentle as you can, and try to roll R36 as little as possible, but in order to clean under the immobilizer, it has to come off, and "I'm sure " its painful for R36. NA-C also stated R36's mostly showed pain upon movement.

R36's care area assessment (CAA) for activities of daily living (ADLs) dated 8/11/17, indicated a history of developmental delay, late onset Alzheimer's disease, with a significant decline and weight loss over past 6 months (prior to nursing home admission) and significant physical deconditioning and weakness. The CAA indicated R36's baseline indicated she answers some questions appropriately and others inappropriately, responded to simple structure and was severely cognitively impaired. The CAA indicated R36 required extensive assist to being dependent with cares, and transferred with assist of 1 and a PAL lift; R36 used a wheel chair for locomotion and was non-ambulatory. A fall risk assessment dated 4/19/18, indicated R36 had long and short-term memory loss, was easily distracted, and mental functions varied over the course of the day. There assessment identified R36 was at risk for falls, and summarized R36 transferred with extensive assist of one and PAL lift, and did not communicate needs effectively or consistently.

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R36's care plan, revised 11/8/17, identified R36's potential for falls related to impaired cognition and mobility, and potential for poor safety awareness, and inability to voice needs adequately. The care plan also identified an ADL/mobility self care deficit. The care plan indicated for bed mobility R36 was extensive to being dependent with assist of one to two, and for transferring, R36 required extensive assist of one with PAL lift or two staff assist.

R36's nursing progress note dated 5/12/18, indicated: Writer is called into R36's room with report of a large bruise on right temple area. Nursing assistant (NA) getting R36 dressed and shows me a very firm hematoma (bruise) It's reported when the NA entered the room. The area measure 6.5 cm (centimeters) by 6 cm x 2 cm raised. R36's right eye is watering and does seem to track my voice as R36 usually does. Gaze is fixed forward, but does have some grimacing or moaning with repositioning and turning. Respirations are short, but not dyspneic (difficulty breathing). Pupils are round and responsive, and R36 does move all 4 extremities actively but does favor right arm. R36 is flushed and diaphoretic (sweating). R36 did have a very large, watery bowel movement this morning after receiving a suppository. Vitals are as follow 97.4 (axillary temperature); 117 (pulse) 24 (respirations) and blood pressure 175 over 84. Ice pack applied to right temple area.

A nursing progress noted dated 5/12/18, indicated primary care provider (PCP)-A evaluated R36 in her room and indicated new area of bruising on right shoulder and elbow. R36 winced and moaned with attempts to move her arm. PCP-A ordered a right shoulder, elbow and abdominal

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X-ray for evaluation of R36.

A review of facility document, Imaging Services, dated 5/12/18, indicated R36 had a "Oblique, angulated, non-displaced fracture proximal right humerus (diagonal fracture of the Right humerus non displaced the near end right humerus).

A physician's progress note dated 5/14/18, indicated primary care provider (PCP)-A was asked to evaluate R36 due to some new areas of bruising identified this morning. The progress note indicated R36 is non-verbal, and completely dependent on others for transitions and mobility. PCP-A's assessment indicated, with attempted movement of the right shoulder and elbow, R36 has grimacing and guarding, and new soft tissue contusion of the right frontal parietal (right side of head above the ear) area with areas of ecchymosis (area of bleeding below skin) that is also developing on the anterior lateral aspect (front side). PCP-A provider's note indicated current areas of bruising are very concerning for injury and trauma, and evening nursing staff were questioned directly by the morning nursing supervisor and deny any falls out of bed, accidents, or injuries. The report indicated staff were unsure how these areas of bruising developed. Night nursing supervisor likewise reports no accidents or injuries reported to her by staff overnight.

An untitled facility incident summary report, dated 5/12/18, indicated the facility self reported an allegation of physical abuse, unexplained injury to the State agency on 5/12/18. The report indicated on 5/12/18, at 7:10 a.m. nursing assistant (NA)-A called licensed practical nurse (LPN)-B into R36's room to report a large hematoma (measuring 6.5

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centimeters x (by) 6 cm x 2 cm) on R36's right temple shortly after coming on shift. R36 was also favoring her right arm. The report indicated the writer arranged for another staff member to care for R36 in case the present nursing assistant (NA)-A was involved with the injury.

A follow up Investigation Summary report was submitted to the State Agency and dated 5/17/18, which indicated R36 had X-rays of the right shoulder, right elbow and abdomen done on 5/12/18. The X-rays revealed R8 had a nondisplaced fracture of the proximal (closest to shoulder) right humerus. A shoulder immobilizer was placed on R36. The investigation summary report indicated on 5/12/18 licensed practical nurse (LPN)-B was called into R36's room by NA-A at 7:10 a.m. to report bruising to R36;'s right temple area. NA-A told LPN-B she found R36 that way and did not know what happened to R36. The following day, LPN-C reported NA-A had confessed to what really happened. After getting R36 partially dressed, she sat her up at the side of bed to transfer using a standing lift. The lift was not at bedside, so the aide turned her back to grab the lift and R36 fell forward onto the floor. NA-A panicked and picked R36 from off the floor, cradled R36 like a baby and placed her back into bed. The NA-A call the nurse. The report indicated NA-A was educated on having the mechanical lift closer to the bed, so that you don't have to turn your back on a resident that is sitting up at the bedside. NA-A was also educated on the importance of not moving a resident before getting a nurse to assess the resident.

When interviewed on 6/6/18 at 10:33 a.m., licensed practical nurse (LPN)-B stated she was

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working the day R36 had the fall (5/12/18), it was on Saturday. LPN-B stated NA-A led me into R36's room and showed me R36 had this big bruise on her face. LPN-B stated NA-A "had no idea" what happened to R36 but found her that way. LPN-B stated NA-A maintained all during the shift she did not know what happened to R36 or how. LPN-B stated my immediate reaction was R36 must have suffered some kind of trauma because the bruise was so large. LPN-B stated she immediately informed the charge nurse, began a set of vital signs and neuro checks, got the doctor involved, who ordered X-rays. LPN B stated during her assessment R36 was sweaty, and "I thought maybe" had a brain aneurysm. LPN-B stated NA-A was re-assigned work groups and did not take care for R36 for the rest of the day. LPN-B stated she suspected NA-A may have known more than was letting on, because of interviews and questions that were asked of NA-A during the shift. LPN-B stated she learned NA-A confessed to what occurred with R36 prior to the start of morning shift the next day, on Sunday (5/13/18). LPN-B stated it was 24 hours before NA-A "fessed up" to what really happened with her and R36. LPN-B stated R36's fall occurred on Saturday, (5/12/18) between the start of the morning shift at 6:00 a.m. and when she was called to the room, around seven or seven-thirty by NA-A. NA-A told her was getting ready to transfer R36 but the lift was not right at the bedside. LPN-B stated R36 fell when NA-A turned to get the lift. NA-A picked R36 up off the floor and placed her back into bed without telling the nurse. LPN-B stated she questioned if placing R36 back to bed caused or made R36's injuries more severe. LPN-B stated NA-A should have reported what happened to R36 "immediately" and not pick R36 off the floor back

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into bed after the fall. LPN-B stated residents, like R36 need a standing lift for transfers, and cannot be left alone at the side of the bed because "you're never sure if they are stable." LPN-B stated "there's a reason why" a resident requires a lift and added "I would not feel comfortable" leaving R36 sit up on her own at the edge of the bed while NA-A got the lift.

When interviewed on 6/6/18, at 10:54 a.m. nursing assistant (NA)-A stated she was working when R36 had the fall, and was responsible for what happened to R36, and lied about it by not telling the nurses what happened right away. NA-A stated she worked that Saturday morning (5/12/18) and was getting R36 up at her usual time, and sat R36 up at the edge for the bed. NA-A stated R36 used a mechanical (PAL) lift for transfers and assistance of one staff. NA-A stated when she was ready to transfer R36, the lift was not in arm's reach. NA-A stated R36 was not supported at the bedside, and she turned her back on R36 to retrieve the lift and left R36 unsupported, which was only "three or four steps away," and R36 fell. NA-A stated R36 should not be left alone at the side of bed, and she should have had the lift right at the bedside. NA-A stated she then "panicked," and put R36 back into bed because "I was nervous, scared, panicked, and thought I would get into more trouble for what really happened." NA-A stated she did not immediately tell staff what happened to R36 on the day, but instead, "I picked R36 up after the fall and put her back into bed." NA-A stated she did not admit to what happened with R36 until the next day, on Sunday (5/13/18). NA-A stated after letting staff know what really happened, she was removed from work and had to meet with the director of nursing. NA-A stated she was

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suspended without pay for three days, was given a written disciplinary notice, and re-educated on proper use and supervision using a lift with a resident.

When interviewed on 6/6/18, at 1:58 p.m. NA-E stated R36 could not sit up alone at the side of bed, and would likely "fall back." NA-E stated that while R36 would not be "one to move too much" when using the stand lift, R36 just was not safe to be left alone.

When interviewed on 6/6/18, at 2:02 p.m. NA-B stated if she had to move R36 with a pal lift, and the lift was not right at hand, she would lay R36 back down on the bed, then move the lift into position. NA-B stated many residents could sit up on their own at the edge of the bed, but R36 "was not very stable."

When interviewed on 6/7/18 at 6:53 a.m., registered nurse (RN)-A stated R36 suffered injures from the fall. RN-A stated R36 had a right shoulder fracture, and extensive bruising on her right side, required X-rays for diagnosing, and some edema (swelling) on the right side from the immobilizer R36 now has to wear. RN-A stated R36 did not fracture her wrist, and had some resulting pain, which now seems more under control.

NA-A's personal file was reviewed and indicated NA-A received education of "Workplace accident and Injury Reduction Program" and "Abuse Prevention," training both dated 3/1/18.

When interviewed on 6/7/18, at 8:47 a.m., the director of nursing (DON) stated she felt R36's fall was an accident, but stated R36 could not be

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F 689	Continued From page 34 trusted and left sitting up, unattended. The DON stated leaving a resident unattended was not what nursing assistants are taught. The DON stated in her meeting she spoke with NA-A that moving R36 after the fall may have caused more harm, and emphasized to NA-A nurses need to make assessment before a resident was moved after any fall and re-education was provided to NA-A. The facility was also monitoring NA-A while she provided transfers and cares to resident, so this incident would not reoccur.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		7/11/18

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F 761	Continued From page 35 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were secured at all times in 1 of 1 medication rooms used. This had the potential to affect 3 residents (R40, R49, R16) whom wandered in the facility and could potentially ingest these medications. Findings include: On observation on 6/4/18, at 1:08 p.m. the medication storage room was inspected with licensed practical nurse (LPN)-B. The doorway to the medication was wide open to the nursing desk / hallway, and the knob was unlocked. LPN-B stated the medication room door was "always opened" to the nursing station and hallway because staff "don't lock it" as the cabinets inside are all locked so medications are secured and unable to be accessed. However, sitting on the back counter of the unlocked medication room was several containers and bottles of medication(s) including: - One opened bottle of Biotene (dental hygiene product which can cause nausea, stomach pain if ingested) with approximately 1/2 of the medication remaining, - One opened bottle of Isoniazid (an antibiotic) 300 milligram (mg) tablets with approximately 20-30 tablets inside, and, - Two opened containers of glycopyrrolate (an anticholinergic medication) 1 mg tablets with each having approximately 15-20 tablets inside. LPN-B explained these medications were for a	F 761	Corrective Action: Licensed staff were educated at the staff meeting on 6/28/2018 that medications need to be secured at all times. No medications can be left unsecured on the counter in the med room. They need to be locked up in a cabinet or behind a locked door. A door with an automatic door closer and a badge reader will be installed to replace the current door. Only licensed staff, TMA's and the ward secretary will be given access to the badge reader. Identification of others: Cognitively impaired and wandering residents were identified during the survey and were included in the statement of deficiency. Measures put into place: Reviewed "Storage of Meds" policy. Staff were re-educated at the staff meeting on on 6/28/2018 that only licensed staff, TMA's and the ward secretary were to be in the med room. A note was also placed in the communication book. Monitoring: The DON/ADON/Designee will monitor to ensure medications are secure at all times in the med room. Will monitor 1 day per week for 2 months, then 2 days per month for 2 months, then as needed. If medications are found to not be secured, the DON/ADON/Designee will provide education with staff involved. These	

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	245341	A. BUILDING _____ B. WING _____	06/07/2018

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

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F 761	Continued From page 36 discharged resident, and are left on the back counter when they are waiting to be destroyed unless they are narcotics. This had been the practice for several years now. LPN-B stated there was typically someone at the counter outside who could stop people from entering the unlocked medication room, however, added on weekends there was only one person usually seated there who often comes to help on the floor leaving the room opened with no staff present. LPN-B stated the room would be "more secured" if it was locked. During subsequent observation on 6/5/18, at 2:56 p.m. the room remained opened with no staff staff present inside the room. Two staff were present at the desk immediately outside the room, however, one was turned away and not facing the medication room while she typed on the computer. The medications identified earlier continued to be sitting on the counter. Further, at 6:46 p.m. the room continued to remain unlocked with only one staff seated outside the room at the computer. On 6/7/18, at 10:54 a.m. the director of nursing (DON) and assistant director of nursing (ADON) stated the stock and prescription medications are locked inside the cabinet(s), so they are not able to be removed without nurses present. However, DON stated if someone was not seated at the nursing station, there was no other way to ensure medications sitting on the counter weren't being taken or removed. ADON expressed the door is sometimes closed, however, still does not physically lock even when closed. It had been this way for a couple years now. ADON stated the consulting pharmacist (CP)-A had never raised a concern about this before, either.	F 761	findings will be reported to the Quarterly QA meeting beginning on 7/11/2018.	

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F 761	Continued From page 37 Further, ADON expressed it was important to ensure medications are secured and not left unsupervised as they could "get into the wrong hands" and potentially consumed. A facility provided List of Residents Who Have Cognitive Impairment and Wander dated 6/7/18, identified R40, R49 and R16 were current residents in the facility and who could potentially wander into the medication room unsupervised. When interviewed on 6/7/18, at 12:52 p.m. CP-A stated the completed audits of the medication room focused on making sure no narcotic medication(s) were left out and unsupervised. CP-A stated she had never noticed medication to be left on the back counter unsupervised before, and added it would be "best practice" for the facility to follow their policy on securing their medications in the medication room. Further, CP-A stated she had never been consulted with regarding leaving the medication room unlocked and added her recommendation would be to lock it "so there is no incident with exposure." A facility provided Storage of Meds policy dated 12/2012, identified the facility would properly store medications to protect residents and follow regulations. A procedure was listed which directed all medications would be placed in locked compartments after receiving them from the pharmacy and listed, "This can be med cart, treatment cart, and med room."	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides-	F 805		7/11/18

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F 805	Continued From page 38 §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the ordered diet texture to 1 of 2 residents (R13) reviewed for nutrition and had a history of pocketing his food. Findings include: R13's quarterly Minimum Data Set (MDS) dated 3/16/18, identified R13 had severe cognitive impairment and required supervision with set up assistance for eating. R13's Speech Therapy and Rehab Progress Note and Discharge Summary dated 5/2/18, identified R13 was receiving puree solid foods after a recent downgrade from regular solids due to pocketing and oral holding. A section labeled, "Plan/Recommendations," directed R13 to, "Continue diet of thin/regular liquids and puree solids [NDD1; National Dysphagia Diet Level 1 - pureed foods with a pudding consistency]." R13's Physician Telephone Order(s) dated 4/30/18, identified an order, "Diet consistency change to puree [with[thin/regular liquids." Further, R13's care plan dated 5/1/18, identified him to consume "a regular pureed diet with thin regular liquids." During observation on 6/6/18, at 9:57 a.m. R13 was wheeled to the commons area in a Broda-style wheelchair and seated at a table along the wall. Nursing assistant (NA)-A brought over a covered styrofoam plate, placed it in front	F 805	Corrective Action: Direct care staff and licensed staff were educated at the staff meeting on 6/28/2018 of the importance of following each residents specific ordered diet. Identification of others: All residents diets were reviewed and their diets were added to the aide assignment sheets to alert staff of each residents current diet orders. Measure put into place: All residents diets were added to the aide assignment sheets to alert staff of each residents current diet orders. Monitoring: The DON/ADON/Designee will monitor random residents outside of the dining room with altered diets 1 time a week for 2 months, then 2 times a month for 2 months, then as needed. If the facility fails to provide the ordered diet texture, the DON/ADON/Designee will provide education with the staff involved. These finding will be reported to the Quality QA meeting beginning on 7/11/2018.	

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F 805	Continued From page 39	F 805		

of R13 on the table and walked away. The plate had a single piece of regular consistency, buttered toast on it which was cut in half. R13 picked up a piece of toast and began to eat is using his right hand. The surveyor alerted another staff, NA-B, to R13 consuming regular consistency food. NA-B responded she was not sure if R13 was allowed to have toast and looked to licensed practical nurse (LPN)-A.

When interviewed on 6/6/18, at 10:00 a.m. NA-A stated R13 consumed a "soft" diet and was able to eat toast or "anything soft" like it without it being pureed. NA-A explained herself and other staff often provided R13 with regular consistency toast for breakfast, and again reiterated he could have "anything soft" in regular form. At 10:11 a.m. R13 had consumed 100% of the provided regular consistency toast without any audible coughing or visible pocketing being observed.

During interview on 6/6/18, at 10:14 a.m. licensed practical nurse (LPN)-A stated she was a "little taken back" when NA-A served R13 regular toast just prior. R13 was to only have a pureed diet with thin liquids, and regular toast would not be considered part of a pureed diet. LPN-A stated serving R13 regular consistency food could be a "choking hazard" for him.

R13's medical record was reviewed and lacked any evidence R13 had been assessed, or provided a risk versus benefit of consuming regular toast despite having physician order and a speech therapy recommendation to consume pureed food(s).

When interviewed on 6/6/18, at 1:22 p.m. registered nurse (RN)-A stated she was not sure

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F 805	Continued From page 40 if R13 had ever been assessed to be able to consume regular toast despite being on a pureed diet, nor did his medical record have any evidence it had been reviewed or screened. RN-A explained residents' still "have the right" to eat foods they want, however, someone should be close by and watch them. RN-A stated she would call speech therapy and have him re-screened with regular toast as they want him to be able to eat his food safely. During interview on 6/6/18, at 2:02 p.m. speech language pathologist (SLP)-A stated R13 consuming regular consistency toast "wasn't brought up" during her original screening, however, it could be assessed and provided if she had been aware. It was important to assess those specific food items to make sure a resident can manage it "OK" during their meals. A facility Standard Diets Available policy dated 4/2017, identified the facility would provide each patient/resident with, "a nourishing, palatable, well balanced diet that meets the daily nutritional and therapeutic needs in the last constricting means."	F 805		
F 880 SS=F	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.	F 880		7/11/18

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F 880	Continued From page 41 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 42 (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 track, trend and analyze infections and potential infections of residents. This had the potential to affect all 48 resident who resided in the facility. Findings include: On 6/7/18, at 8:00 a.m. and 9:30 a.m. the last six months infection control line listing was requested for review from the assistant director of nursing (ADON). During interview on 6/7/18, at 10:23 a.m. registered nurse (RN)-B stated she had recently started tracking infection for the care center. The facility currently tracked antibiotic use only for their antibiotic stewardship program, to ensure appropriate antibiotic use. RN-B stated she met weekly with facility staff and discussed resident potential infections and actual infections; however, they were not tracked or compared for	F 880	Corrective Action: Licensed staff were educated at the staff meeting on 6/28/2018 on the infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. A surveillance log was developed to track, trend and analyze infections and potential infections of residents. Identification of others: All of the residents and/or staff have the potential to be affected. Measures put in place: A surveillance log was developed to track, trend and analyze infections and potential infections of residents. This log will be reviewed with the infection control nurse weekly to determine if there are any trends or patterns between resident	

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F 880	Continued From page 43 trending's or patterns. She did not complete a monthly analysis of the resident infections for trends or patterns or what the facility did when patterns or trends were identified. Further it was important to track, trend and analyze infections in the facility for prevention and education. The facility provided a Long Term Care - Antibiotic Log, which was a running log from 2/22/18, through 6/4/18. The form identified resident name, antibiotic, start and stop date, whether the culture was reviewed, whether a new antibiotic was needed, whether an infection control report was completed, when it was resolved. The facility provided a Nursing Home Infection Control Report Year 2017- 2018. The form provided a tally of the number and type of infections from July 2017, through March 2018 and identified the following: - January 2018, four upper respirator infections, one skin infection, three ENT (ear nose throat/mouth) infections and one case of influenza. - February 2018, one urinary tract infection, one ENT infection, - March 2018, two lower respiratory infections, two skin infections, one ENT infection, one sepsis infection and one case of influenza. The form lacked infection tallies for April, May and June of 2018. The facility did not provide any analysis of the infections to include trending, patterns and what	F 880	illness and/or staff illnesses. An "Absentee Tracking, Staff Illness" form is also used at the facility to track and trend employee illnesses along with resident illnesses. Monitoring: This log will be reviewed with the infection control nurse weekly to determine if there are any trends or patterns between resident illness and/or staff illnesses. These finding will be reported to the Quality QA meeting beginning on 7/11/2018.	

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F 880	Continued From page 44 interventions were implemented, if patterns or trends were identified. The facility did not provide a line listing of current infections and potential infections that included: date, resident name, room number, type of infection, signs and symptoms, medications, causative organism, whether acquired in or out of the facility, if the infection required isolation precaution and resolution of the infection. During interview on 6/7/18, at 10:37 a.m. ADON stated the facility used to track, trend and analyze potential and actual infections of residents; however, there must have been some confusion on the process when job duties were given to RN-B and when they started their antibiotic stewardship program they stopped tracking all potential and actual infection. The facility policy Infection Prevention and Control Plan- Long Term care dated 11/17, identified a comprehensive infection control and prevention plan would be implemented to provide a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases in residents.	F 880		

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K 000	INITIAL COMMENTS 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Centracare Health System Sauk Centre Nursing Home 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2018

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Centracare Health System Sauk Centre Nursing Home is a 2 story building with no basement and is fully sprinkler protected. The original building was constructed in 1973 and was determined to be of Type II(222) construction. In 1994, an addition was added to the east that was determined to be of Type II(111) construction. In 2008 the facility moved the 2 hr separation in the West wing adding 6 resident rooms to the Nursing Home. The addition was part of the original hospital constructed in 1949 and was determined to be of Type II (222) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, installed in accordance with NFPA 72	K 000		

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K 000	Continued From page 2 "The National Fire Alarm Code" (2010 edition). The fire alarm system is monitored for automatic fire department notification. All hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code 2015 edition. The facility has a capacity of 60 beds and had a census of 49 at the time of the survey. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	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 REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 49 out of 49 residents.	K 345	The Fire Alarm System and its devices was tested on 6/27/2018. This deficiency was shown to our Fire Alarm System Maintenance Company Vendor, and they as well as CentraCare Health Sauk Centre□s Facilities Staff will include this annual test on their Preventative	7/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**06/04/2018**

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

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K 345	Continued From page 3 Findings include: On facility tour between 8:00 AM and 11:00 AM on 06/04/2018, documentation reviewed revealed: 1. The most recent Fire Alarm Annual Testing was completed on 06/16/2017, the previous annual inspection was completed on 5/2/2016. More than the time allowed per NFPA 72. This deficient condition was confirmed by the Director of Maintenance.	K 345	Maintenance Schedules to prevent testing from occurring longer than a twelve-month period.	
K 353 SS=F	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 REQUIREMENT is not met as evidenced by:	K 353		7/11/18

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CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	**425 N ELM STREET** **SAUK CENTRE, MN 56378**

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K 353	Continued From page 4 Based on observation and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of 49 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:00 am on 06/04/2018, record review and staff interview revealed there was no record of a flow test in the 4th quarter of 2017. This deficient condition was confirmed by the Director of Maintenance.	K 353	a) A complete test of the Sprinkler System was done 6/27/18. A flow test of the Sprinkler System was done on 6/19/18. b) Simplex Grinnell was the Vendor who tested the Sprinkler System on 6/27/18. The flow test of the Sprinkler System was done by CentraCare Health Sauk Centre Facilities Staff members Don Jennissen, Justin Sebek and Michael Wanderscheid. c) The water supply source for the Sprinkler System is the City of Sauk Centre, MN. Prior to the inspection, quarterly flow testing took place alternatively between the Hospital and Nursing Home systems, resulting in some missed quarterly testing of each system. Going forward, each of these systems will be tested quarterly throughout the year by CentraCare Health Sauk Centre Facilities Staff, with complete system testing of both systems done by an approved Fire/Sprinkler System Vendor.	
K 761 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	K 761		7/11/18

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CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	**425 N ELM STREET** **SAUK CENTRE, MN 56378**

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K 761	Continued From page 5 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition and the NFPA 80 Standard for Fire Doors and other openings Protective's 2010 edition. This deficient practice could affect all residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: During documentation review on 06/04/2018, during documentation review, the facility failed to complete the annual fire door inspection for all of the fire rated doors located throughout the facility. Last inspection was 03/29/2017. This deficient condition was confirmed by the Director of Maintenance.	K 761	The annual Fire Door inspection was conducted June 27th, 2018. The results of this inspection and any repairs/replacements made will be available in the CentraCare Health Sauk Centre Facilities Manager□s office. This will be monitored by the facilities manager.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		7/11/18

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K 901	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all patients. Findings include: During documentation review between on 06/04/2018, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the Director of Maintenance.	K 901	A risk assessment will be compiled on electrical (normal and emergency) equipment and systems, Heating, Ventilation, and Air Conditioning systems, and Medical Gas Systems. CentraCare Health Sauk Centre Facilities Staff will evaluate these components on a category 1-4 risk scale. The Risk Assessment will be conducted prior to use of new equipment and will be reviewed annually to remove equipment no longer in use in the Facility. The Risk Assessment will be recorded, and available for review in the CentraCare Health Sauk Centre Facilities Manager□s office. The Risk Assessment will be completed by July 11th, 2018.	
K 912 SS=F	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover.	K 912		7/11/18

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K 912	Continued From page 7 If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This deficient practice could affect 49 of 49 residents. Findings include: During documentation review on 06/04/2018, documentation could not be located to show that an electrical outlet inspection had occurred throughout the facility. This deficient condition was confirmed by the Director of Maintenance.	K 912	Electrical outlets will be tested in Resident Rooms and Resident Activity Areas June 25 thru June 29, 2018 and annually thereafter. Documentation of this testing and repairs/replacement will be kept in the CentraCare Health Sauk Centre Facilities Manager□s office for review.	