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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HDK3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00393

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245447**
2.STATE VENDOR OR MEDICAID NO.
(L2) **935742400**

3. NAME AND ADDRESS OF FACILITY
(L3) **SACRED HEART CARE CENTER**
(L4) **1200 12TH STREET SOUTHWEST**
(L5) **AUSTIN, MN** (L6) **55912**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 09/16/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **59** (L18)

13.Total Certified Beds **59** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	59			
(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):

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective September 3, 2013, the facility is certified for 59 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Kyla Einertson, HFE, NEII 11/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist 12/26/2013 (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
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/27/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5447 December 26, 2013

Ms. Rebecca Mathews Halverson, Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, Minnesota 55912

Dear Ms. Mathews Halverson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 3, 2013, the above facility is certified for:

59 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 59 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 19, 2013

Ms. Rebecca Mathews Halverson, Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, Minnesota 55912

RE: Project Number S5447023

Dear Ms. Mathews Halverson:

On August 7, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 25, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 16, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 31, 2013 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 July 25, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 3, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 25, 2013, effective September 3, 2013 and therefore remedies outlined in our letter to you dated August 7, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245447	A. Building B. Wing	9/16/2013

Name of Facility	Street Address, City, State, Zip Code
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **08/28/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/28/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/03/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/30/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/28/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/AK	11/19/2013	31221	09/16/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/25/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245447	A. Building B. Wing 01 - MAIN BUILDING 01	8/31/2013

Name of Facility	Street Address, City, State, Zip Code
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0038	08/16/2013	ID Prefix Reg. # NFPA 101 LSC K0056	08/30/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	11/19/2013	25822	08/31/2013
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/23/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HDK3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00393

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245447**
2.STATE VENDOR OR MEDICAID NO.
(L2) **935742400**

3. NAME AND ADDRESS OF FACILITY
(L3)
(L4) **SACRED HEART CARE CENTER**
1200 12TH STREET SOUTHWEST
(L5) **AUSTIN, MN** (L6) **55912**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/25/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **59** (L18)

13.Total Certified Beds **59** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	59			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Kyla Einertson, HFE NE II — 08/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/27/2013 (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
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/27/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN: 245447

At the time of the standard survey completed July 25, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5131

August 7, 2013

Ms. Rebecca Mathews Halverson, Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, Minnesota 55912

RE: Project Number S5447023

Dear Ms. Mathews Halverson:

On July 25, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731
Fax: (507) 206-2731

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 3, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 25, 2013 (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 January 25, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

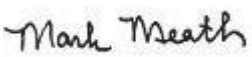
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4118 Fax: (651) 281-9697

Enclosure

cc: Licensing and Certification File 5447s13.rtf

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ AUG 19 2013 B. WING _____ MN Dept of Health Receipt	07/25/2013

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 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	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because the provisions of federal law require it.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	8/19/13 DPN As noted, when these two incidents occurred, Sacred Heart Care Center had policies in place that reflected the reporting requirements for suspected or alleged maltreatment, including the need for immediate notification to the Administrator and OHFC. The nurses who failed to immediately report to the Administrator and OHFC were out of compliance with facility policies and were counseled accordingly. They did, however, document the allegation of theft and the discovery of a hip fracture of unknown origin, which led to the notification of the Administrator and OHFC the following day. After investigation both reports were cleared by OHFC without the need for any further action.	8/28/13 DPN

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Mathews Halverson	ADMINISTRATOR	8/16/13

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	07/25/2013

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of an injury of unknown origin (fracture) and financial exploitation immediately to the administrator and designated state agency (Office of Health & Facility Complaints [OHFC] division of Minnesota Department of Health-MDH) for 2 of 3 residents (R25, R30) reviewed for abuse prohibition. Findings include: R25 had an incident report completed on 6/25/2013 which stated there had been an allegation of injury of unknown origin which had been identified on 6/23/2013 and subsequent fracture of the right hip which had been identified on 6/24/2013. However; the administrator and OHFC had not been notified until 06/25/2013 which was one day after the fracture was found by X-Ray. R30 had an incident report completed on 4/3/2013 which stated there had been an	F 225	All employees routinely receive training on maltreatment policies during orientation, at annual education sessions, and intermittently at departmental meetings. These practices will continue with a thorough review of survey findings during this year's annual education, which was scheduled before the survey to occur on August 12th, 21st, and 28th. A mandatory nurses' meeting was also held on August 13th. The primary focus was additional education about maltreatment policies and the need to report immediately even if it is doubtful that maltreatment has occurred. This education will continue at nurses' meetings and individually as needed. The DON and Clinical Managers will continue to read routine charting. If any maltreatment reporting has been missed, required notifications will take place immediately and the nurse who should have done the notifications earlier will receive counseling and disciplinary action as appropriate. The DON is responsible for monitoring this process and for reporting and addressing any related issues at quarterly Quality Assurance meetings. Completion Date: August 28, 2013 and Ongoing	

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F 225	Continued From page 2 allegation of financial exploitation identified on 4/2/2013. However; the administrator and OHFC had not been notified until the next day on 04/03/2013. On 7/24/2013 at 11:35 a.m., the director of nursing (DON) was interviewed regarding the process for abuse/neglect. She stated the staff was to report immediately to their supervisor. A new updated vulnerable adult (VA) policy had been developed in June 2013. DON continued to say that the staff is to notify the administrator when in the building immediately. There are several people they can report to (identified in the VA policy) including Clinical Manager, DON, and charge nurses when the administrator was not in the building. The OHFC/MDH offices were to be notified immediately and this had been discussed at a prior nurse's meeting held April 2013. The DON verified R25's and R30's reports of allegations of abuse/neglect and financial exploitation had not been reported immediately to Administrator or to OHFC/MDH. On 7/24/2013 at 12:00 p.m. the Administrator was interviewed regarding the facility process for handling Abuse/neglect allegations. The administrator said that staff was to take immediate action, call the police, remove the resident and keep them safe, and report it to their charge nurse. If she (administrator) was in the building, they would let her know. If she wasn't in the building, the staff was to call the registered nurse (RN) on call depending on what it was and then it would be reported to the administrator. The administrator indicated she would expect staff to notify her in most cases. The administrator continued to say that the reporting should be immediate because that was what the	F 225		

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F 225	Continued From page 3 guidance in the bulletin said from MDH. The Bulletin referenced was bulletin 13-01 on Immediate Reporting to Administrator for allegations of abuse/neglect. The facility policy and procedures dated 6/2013 for PROHIBITION OF MALTREATMENT INTERNAL REPORTING SACRED HEART SNF was reviewed. It read: "Any employee of Sacred Heart Care Center who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury that is not reasonably explained, may meet their mandated reporting obligation by immediately reporting such information to the Administrator or any supervisor, including the Charge Nurse. When in the facility, the Administrator must be immediately informed (by the reporter, the person receiving the report, a Clinical Manager, or the Director of Nursing) of all violations involving mistreatment, neglect, or abuse, including injuries of an unknown source* and misappropriation of resident property." The EXTERNAL REPORTING MALTREATMENT TO STATE AND COUNTY AGENCIES SACRED HEART SNF section of the policy was reviewed and read: "All alleged, suspected, or possible violations and all substantiated incidents of maltreatment will be immediately reported to appropriate state and county agencies as required by law."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		8/28/13

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F 226	Continued From page 4	F 226		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure staff followed the facility abuse prevention plan for reporting immediately allegations of abuse to the administrator and state agency for 2 of 3 residents (R25, R30) reviewed with an abuse/neglect and financial exploitation. This had the potential to affect all 55 residents in the facility.

Findings include:

R25 had an allegation of injury of unknown origin and subsequent fracture of the right hip, identified on 6/23/2013. However; the administrator and OHFC had not been notified until 06/25/2013 which was two days later vs. being reported immediately on being reported of having a fractured leg from the hospital.

R30 had reported missing $95 dollars from her purse which was reported to a nursing assistant and licensed practical nurse at 7:15 p.m. on 4/2/2013. However, the designated state agency (Office of Health and Facility Complaints-OHFC) had been contacted the next day (4/3/2013) and not immediately when the resident reported the stolen/missing monies.

On 7/24/2013 at 11:35 a.m., the director of nursing (DON) was interviewed regarding the process for abuse/neglect allegations. She stated the staff was to notify the administrator when in the building immediately. The OHFC/MDH

As noted, when these two incidents occurred, Sacred Heart Care Center had policies in place that reflected the reporting requirements for suspected or alleged maltreatment, including the need for immediate notification to the Administrator and OHFC. The nurses who failed to immediately report to the Administrator and OHFC were out of compliance with facility policies and were counseled accordingly. They did, however, document the allegation of theft and the discovery of a hip fracture of unknown origin, which led to the notification of the Administrator and OHFC the following day. After investigation both reports were cleared by OHFC without the need for any further action.

All employees routinely receive training on maltreatment policies during orientation, at annual education sessions, and intermittently at departmental meetings. These practices will continue with a thorough review of survey findings during this year's annual education, which was scheduled before the survey to occur on August 12th, 21st, and 28th.

A mandatory nurses' meeting was also held on August 13th. The primary focus was additional education about maltreatment policies and the need to report immediately even if it is doubtful that maltreatment has occurred. This education will continue at nurses' meetings and individually as needed.

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F 226	Continued From page 5 offices were to be notified immediately. The DON verified R25's and R30's VA reports were not reported immediately to Administrator or OHFC/MDH. On 7/24/2013 at 12 noon, the Administrator was interviewed regarding the facility process for handling Abuse/neglect allegations. The administrator indicated she would expect staff to notify her in most cases and, the staff knows that. The facility policy and procedures dated 6/2013 for PROHIBITION OF MALTREATMENT INTERNAL REPORTING SACRED HEART SNF was reviewed. It read: "Any employee of Sacred Heart Care Center who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury that is not reasonably explained, may meet their mandated reporting obligation by immediately reporting such information to the Administrator or any supervisor, including the Charge Nurse. When in the facility, the Administrator must be immediately informed (by the reporter, the person receiving the report, a Clinical Manager, or the Director of Nursing) of all violations involving mistreatment, neglect, or abuse, including injuries of an unknown source* and misappropriation of resident property." The EXTERNAL REPORTING MALTREATMENT TO STATE AND COUNTY AGENCIES SACRED HEART SN section of the policy was reviewed and read: "All alleged, suspected, or possible violations and all substantiated incidents of maltreatment will be immediately reported to appropriate state and county agencies as required by law."	F 226	The DON and Clinical Managers will continue to read routine charting. If any maltreatment reporting has been missed, required notifications will take place immediately and the nurse who should have done the notifications earlier will receive counseling and disciplinary action as appropriate. The DON is responsible for monitoring this process and for reporting and addressing any related issues at quarterly Quality Assurance meetings. Completion Date: August 28, 2013 and Ongoing	
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241 SS=D	Continued From page 6 INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, smell, interview and document review, the facility failed to promote an environment free from urine odors to enhance dignity for 1 of 1 resident (R44) who had been reviewed for urinary incontinence. Findings include: R44 was admitted on 12/30/10 with diagnoses that included but not limited to female stress incontinence, functional incontinence and mixed incontinence. During observation on 7/22/13, at 6:33 p.m. a strong urine odor was smelled when walking past R44's room and upon entering R44 ' s room the odor intensified. On 7/23/13, at 9:49 a.m. again a strong urine odor was noted in R44's room. On 7/24/13, from 7:08 a.m. until 10:26 a.m. again a strong urine odor was noted in R44's room. On 7/25/13, at 8:22 a.m. again a urine odor remained in R44's room. As noted the urine smell was present on various times of the day and evening and on all four days of the survey. During interview on 7/24/13, at 11:07 a.m. licensed practical nurse (LPN)-A indicated the strong urine odor was coming from the bathroom. LPN-A indicated the family had removed the cloth	F 241	Sacred Heart Care Center strives to maintain an environment free of offensive odors. R44 has a history of odoriferous urine and, as noted, was actually tested for a UTI shortly before the survey. The result was negative. Also prior to and during the survey, maintenance was treating and/or shampooing the carpet on an almost daily basis. This has continued since that time with only temporarily satisfactory results. On 8/14/13, with the family's permission, R44 was moved to a room that has a tile floor rather than carpet. The previous room is being thoroughly cleaned, with carpet shampooing continuing. The room will not be occupied until there is no offensive odor noted. The carpet will be replaced if necessary. The Wing 3 Clinical Manager and Maintenance will continue to check the room frequently for odor and take additional measures as needed. No other rooms or areas within the facility were noted to have an ongoing odor. Re-education was provided to nursing staff on August 13th and 14th regarding the need to report any ongoing odor to the appropriate people so that interventions will be timely. Completion Date: Ongoing	9/3/13

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F 241	Continued From page 7 recliner chair from the resident room which had a urine smell. However, the room still smelled of urine. During interview on 7/24/13, at 11:15 a.m. housekeeper-A indicated R44 ' s bathroom is mopped down and sprayed daily. Housekeeper-A indicated they had not felt the urine odor was coming from the bathroom but the room. Housekeeper-A indicated they currently use a chemical deodorizer to helps with odors but the spray had not fix the problem and was only a temporary mask to the odor. During interview on 7/25/13, at 8:31 a.m. registered nurse (RN)-A indicated R44 would take incontinent product off them and throw it on the floor. RN-A verified a urinalysis was completed due to the foul urine smell on 7/19/13 and was negative for a urinary tract infection. RN-A indicated they had changed the cloth recliner chair within the past month and the floor was cleaned constantly to reduce urine odors for R44. RN-A indicated the source of the urine odor might be the carpeting in the room. RN-A also indicated R44 was not aware of the odor due to decline in mental status. During interview on 7/25/13, at 8:24 a.m. the maintenance director verified the carpet was to be cleaned every day however, deep cleaning the carpet will wreck the carpet if done frequently. Maintenance director indicated the odor was probably coming from the chair and was not able to do any cleaning with the cloth chair. Maintenance director indicated they needed to locate the source of the odor before they can find a solution. At 10:20 a.m., maintenance director removed the cloth recliner from R44 ' s room and	F 241		

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F 241	Continued From page 8 indicated they had planned to shampoo the carpet today. During interview on 7/25/13, at 1:24 p.m. maintenance-A identified an email had been sent to the director of nursing and clinical manager about a month ago when housekeeping noted the urine odor had been getting worse in R44 ' s room. Maintenance-A indicated staff had been shampooing the clothe chair quite often and had been spraying chemical for odor without success. Maintenance also had been aware of R44 ' s family had removed the cloth recliner chair and replaced with the current cloth chair the end of June 2013. Maintenance-A identified if an issue needing housekeeping or maintenance assistance the nurse/s would email maintenance or complete a blue slip for an order request.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for a toileting plan for 1 of 1 resident (R44) reviewed for urinary incontinence. Findings include: R44 was not toileted for three hours and 18 minutes however; the care plan said that R44	F 282	It is the policy of Sacred Heart Care Center that a Care Plan is developed that has specific, individualized approaches for each resident. Relevant information from the Care Plan is condensed on a Nursing Assistant Care Sheet. Nursing assistants carry this sheet with them and have been trained to consult it frequently while providing care. They have also been trained to document care only after it is given. (NA)-A was seriously out of compliance with facility policies by documenting care that was not given and disciplinary action was taken.	

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F 282	Continued From page 9 was to be toileted every two hours or as needed. R44 was admitted on 12/30/10, with diagnoses that included but not limited to female stress incontinence, mixed incontinence, functional incontinence and dementia. R44's care plan dated 1/19/11 indicated altered elimination (urinary) related to frequently incontinent of urine, functional incontinence, stress incontinence, wears pads and decreased sensation of need to void at times. Nursing assistant care sheet directed staff to toilet resident every two hours and as needed. During constant observation on 7/24/13, from 7:08 a.m. until 10:26 a.m. (three hours and 18 minutes) R44 had not been toileted or offered the toilet. During review of July 2013 voiding repositioning record indicated R44 was successfully toileted at 8:50 a.m. and 9:50 a.m. During interview on 7/24/13, at 10:40 a.m. nursing assistant (NA)-A confirmed had documented for R44 but had not toileted resident as indicated on the form. During interview on 7/24/13, at 11:07 a.m. licensed practical nurse-A identified the care sheet indicated resident was independent but was to be offered the bathroom every two hours and as needed. During interview on 7/25/13, at 8:31 a.m. registered nurse (RN)-A indicated R44 had deteriorated and needed to be taken in to the bathroom every two hours and checked and changed as needed. RN-A said that they expect staff to take R44 into the bathroom and make	F 282	Floor nurses will be assigned to audit the toileting schedule and nursing assistant documentation for a defined period of time (i.e., four hours) for an individual resident 2 times per week for each wing. These audits will begin the week of August 19th and will continue until the October Quality Assurance meeting. Any issues and the need for continued audits will be discussed at that meeting. The Clinical Managers will be responsible for assigning audits and ensuring that they are completed as required. Completion Date: August 30, 2013 and Ongoing 8/30/13 sph	

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F 282	Continued From page 10 sure they clean perineal area well. At 2:27 p.m. RN-A indicated the care sheets are updated every week and would expect the nursing assistant to follow the nursing assistant care sheet for R44. During interview on 7/25/13, at 2:35 p.m. the director of nursing stated they would expect the nursing assistants to follow the care sheet and the care plan as that was what staff was educated to do. During review of CARE SHEET-NURSING ASSISTANT policy dated 10/20/05, directed staff to carry assignment sheets with them and to refer to them as care was given to residents. Information included on the assignment sheet included bladder programs.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide bladder program services based on the comprehensive	F 315	It is the policy of Sacred Heart Care Center to provide individualized services based on the care plan for each resident. (NA)-A was out of compliance with facility policies by not toileting a resident in accordance with that resident's care plan and disciplinary action was taken. The need to provide all services defined by the care plan was/will be discussed with all employees during annual education on August 12th, 21st, and 28th and at nursing department meetings on August 13th and 14th. Completion Date: August 28, 2013 8/28/13	

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F 315	Continued From page 11 bladder assessment to prevent bladder decline and/or prevent urinary infections for 1 of 1 resident (R44) reviewed for chronic urinary incontinence. Findings include: R44 had not been toileted every two hours or less on July 24, 2013 when R44 went three hours and 18 minutes between being toileted and was incontinent of urine at the time of toileting. R44 was admitted on 12/30/10, with diagnoses that included but not limited to female stress incontinence, mixed incontinence, functional incontinence and dementia. R44's annual Minimum Data Set (MDS) dated 6/19/13, identified R44 had severe cognitive impairment, was on a toileting program, frequently incontinent of bladder and required extensive assistance with toileting needs. Bladder assessment dated 6/19/13; identified R44 was incontinent of bladder and was on a scheduled toileting plan. R44's care plan dated 1/19/11, read they had altered urinary elimination related to frequently incontinent of urine, functional incontinence, stress incontinence, wears pads and decreased sensation of need to void at times. Nursing assistant care sheet directed caregiver staff to toilet resident every two hours and as needed. During constant observation on 7/24/13, from 7:08 a.m. until 10:26 a.m. a total of three hours and 18 minutes R44 had not been toileted or offered the toilet. During review of July 2013 voiding and repositioning record indicated R44 was	F 315		

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	07/25/2013

IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 12 successfully toileted at 8:50 a.m. and 9:50 a.m. During interview on 7/24/13, at 10:40 a.m. nursing assistant (NA)-A confirmed they had not toileted resident as indicated on the toileting form. During interview on 7/25/13, at 8:31 a.m. registered nurse (RN)-A indicated R44 had deteriorated and needs to be taken in to the bathroom every two hours and checked and changed as needed. RN-A said they expect staff to take R44 into the bathroom and make sure they complete perineal care. At 2:27 p.m. RN-A indicated the care sheets are updated every week and would expect the nursing assistant to follow the nursing assistant care sheet. During interview on 7/25/13, at 2:35 p.m. the director of nursing said they would expect the nursing assistants to follow the resident ' s care sheet and the information on the care plan as that was what staff were educated to do. During review of CARE SHEET-NURSING ASSISTANT policy dated 10/20/05, it directed staff to carry assignment sheets with them and to refer to them as care was given to residents. Information included on the assignment sheet included bladder programs.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

DC: 09.03.2013

FIRE SAFETY

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.

EXIT: 07.25.2013

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Sacred Heart Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

POC ok
8-23-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Matthews Halverson	ADMINISTRATOR	8/16/13

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...llowing 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 ...ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST** **AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

By email to:
Barbara.Lundberg@state.mn.us and
Marian.Whitney@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.

This facility will be surveyed as two separate buildings. Sacred Heart Care Center is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1997, addition was constructed to the West Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST** **AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a capacity of 59 beds and had a census of 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., 7.1.6.2 and 7.2.1.4.5. The deficient practice could affect 20 out of 53 residents. Findings include: On facility tour between 9:00 AM and 12 Noon on 07/23/2013, observation revealed, that the following was found: 1. 1st floor - wing 1 exit discharge has a change in elevation of more than 1/2 inch from door threshold to concrete sidewalk 2. 1st floor - central core NW exit sidewalk to public way has a change in elevation of more than 1/2 inch	K 038	The facility has replaced sidewalk sections to bring the change in elevation at these two exits to ½ inch or less. Completion Date: August 16, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 3 These deficient practices were confirmed by the Facility Maintenance Director (RK) at the time of discovery.	K 038		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7 and 1999 NFPA 13, 5-13.6. The deficient practice could affect 10 out 56 residents. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12 Noon on 07/23/2013, observation revealed that the 1st floor coat closet by physical therapy is not properly fire sprinkler protected. Pendant	K 056	A new ceiling has been installed in the first floor coat closet by physical therapy and the sprinkler head will be lowered into the closet. Completion Date: August 30, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST** **AUSTIN, MN 55912**

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K 056	Continued From page 4 sprinkler head is more than 12 inches from ceiling. This deficient practice was confirmed by the Facility Maintenance Director (JM) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 056		

F 5447021

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

Printed: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**07/23/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST AUSTIN, MN 55912**

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K 000	INITIAL COMMENTS Surveyor: 25822 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Sacred Heart Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. This facility will be surveyed as two separate buildings. Sacred Heart Care Center, In 2007, an addition was constructed that was determined to be of Type II (111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 59 beds and had a census of 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		

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

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