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September 14, 2016

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

Subject: Sacred Heart Care Center
Provider # 245447
Project # S5447026

Dear Ms. Mathews Halverson:

This is in response to your letter of July 21, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F278 and F441 issued pursuant to the survey event LKO911, completed on June 30, 2016.

The information presented with your letter, the CMS 2567 dated June 30, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F278 S/S D 42 CFR § 483.20(g) Assessment/Accuracy/Coordination/Certified

- The assessment must accurately reflect the resident's status.
- A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
- A registered nurse must sign and certify that the assessment is completed.
- Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
- Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

- Clinical disagreement does not constitute a material and false statement.

Summary of the facility's reason for IDR of this tag:
The facility disagrees that they should have coded the staff assistance with emptying the catheter as toileting assistance on the MDS. They assert their recent case mix audits indicated they had been coding the MDS assessments correctly.

Summary of Facts:

During surveyor observations on June 29, 2016, a nursing assistant (NA)-A was observed to provide R18 care including emptying R18's catheter drainage bag. The Minimum Data Set (MDS) dated 4/13/16, did not indicate extensive assistance with toileting due to R18's need for assistance to empty the catheter drainage bag. The facility RAI (Resident Assessment Instrument) MDS manual dated October 2015, indicates facilities should not include emptying of an indwelling catheter drainage bag under the toileting assistance area of the assessment: "Do NOT include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 I."

Conclusion:
This is not a valid example of a deficient practice under this regulation and therefore the deficiency will be removed from the Statement of Deficiencies.

F441 S/S-F 42 CFR 483.65 (n) Infection Control: The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

§483.65(a) Infection Control Program
The facility must establish an Infection Control Program under which it –
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.
§483.65(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) 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.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.
§483.65(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

Summary of the facility's reason for IDR of this tag:
The facility indicated they maintain an efficient Infection Control Program that reflects trending and analysis of data collected to reduce the risk of infection transmission. The facility indicated that

although they have not formalized their processes for documenting specific infection trending and analysis patterns, their systems function. The facility also asserts this deficiency is not a systems issue as evidenced by only one resident having been identified in the deficiency.

Summary of Facts:
The facility provided printout documents during the survey which indicated which resident(s) had received antibiotic(s) from April 1, 2016 through June 30, 2016, with the corresponding diagnoses for the antibiotic use.

The facility had provided documents during the survey which indicated which units (facility map) had residents who had experienced infections. The infections identified on the facility map dated April 2016 through June 2016, included urinary tract infections, upper respiratory infections, skin, gastrointestinal and other. A review of the form revealed only the date of the infection, the room the resident with the infection was located in, and inconsistently documented the diagnoses for the antibiotic use.

The facility provided a third form, Monthly Infection Report for Individual Nursing Units from April 2016 through June 30, 2016. The form identified the name of the resident, date of infection, whether the infection was nosocomial or not, diagnosis, infection site, symptoms, culture/pathogen, treatment and medication orders, and remarks/interventions. The form for Wing 1 identified two residents with an infection. However, the facility map identified seven residents who had experienced an infection. Wing 2 identified one resident with an infection however, the map identified five resident who had experienced infections. Wing 3 documentation indicated no residents with an infection however, the corresponding map identified six residents with an infection. The April form was inconsistent regarding documentation of whether infections were nosocomial or not, what symptoms were present, culture/pathogens, treatment and medication orders, and remarks/interventions. In addition a note on the Wing 1 report for the month of May 2016, indicated the facility was to utilize the printout form and add a section to identify which bacteria were present and the infection site. However, the forms the facility provided for May and June 2016, failed to include either. In addition, all three forms lacked monitoring and/or documentation of infections, including tracking and analyzing outbreaks of infection, as well as implementing and documenting actions to resolve related problems.

The facility's policy and procedure for Infection Control was requested but was not provided.

Conclusion:
The facility failed to ensure the infection control program included all components including: planning, organizing, implementing, operating, monitoring and maintaining all elements of the program in order to ensure the facility's interdisciplinary team was involved in infection prevention and control. The facility did not have a current program in place that included surveillance, including process and outcome surveillance, monitoring, data analysis, documentation and communicable disease reporting.

This is a valid deficiency at this tag and at the correct Scope and Severity of F (Widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy).

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-3792 Fax: 651-215-9697

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gary Nederhoff, Rochester District Office Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	06/30/2016

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SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation were also completed at the time of the standard survey. The investigation of complaint H5447008 was completed and found not to be substantiated.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess mood changes after a substantial increase in depressive symptoms for 1 of 5 residents (R58) reviewed for unnecessary medications.	F 250	It is the practice of Sacred Heart Care Center to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.	7/19/16

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

Electronically Signed | 07/21/2016

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F 250	Continued From page 1 Findings included: R58 had been observed on 6/27/16, at 3:07 p.m., 6/28/16, at 9:03 a.m., and 6/29/16 at 11:00 a.m. R58 was lying in bed awake. During an interview on 6/29/16, at 8:58 a.m. while R58 was lying in bed awake. In response to the question, "I noticed you stay in your room, is there a reason you like to be alone?" R58 stated, "I don't know where to go or what to do and when I talk to people they look at me like I'm a stupid idiot." R58 stated sometimes she feels sad. R58 was then asked, "How do staff help you with your depression?" R58 responded, "I suppose they talk to me about it, but I don't know how often." After several more minutes of conversation, R58's sentence structure was not comprehendible for meaning. R58 had diagnoses of dementia with behavioral disturbance, major depressive disorder, restlessness and agitation, anxiety disorder, and abnormal weight loss according to the facility admission record. R58's last Care Area Assessment performed on 12/29/15 included, "PHQ-9 [a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression] score of (04) remains low. She consistently admits to feeling tired (almost all the time) and having occasional down/sad days but denied difficulty with any of the remaining items. Current medication therapy for her depression remains beneficial [Celexa, Mirtazapine, Divalproex for migraines but also used to control mood, and Quetiapine]. No additional issues or concerns with this review. Will continue to monitor for potential changes in cognition and mood and address PRN [as needed]." R58's quarterly Minimum Data Set (MDS) dated	F 250	Another PHQ-9 was administered to R58 on 6/29/16 with a resulting score of 10. RN-A also initiated behavioral charting on every shift for R58. The physician was notified on 6/29/16 of the four most recent scores on the PHQ-9. He expressed that the PHQ-9 is not a valid assessment instrument for nursing home residents with dementia, noting that staff observations are much better indicators of mood. He will see the resident on 7/19/2016 and determine at that time if any treatment changes are warranted. The family was notified of the change in the PHQ-9 scores on 6/29/16 as well as the fact that nursing had not reported anything different about R58□s behaviors. Daughter stated that family had also not seen any change in mood. The behavioral progress note dated 5/11/16 stated in its entirety: The target behavior we are monitoring is □Accusing staff of lying to her.□ In the month of January, the target behavior did not occur. In the month of February, again, the target behavior did not occur. In the month of March, the target behavior did occur x 1 and the month of April it occurred x 3. Facility does not agree that the phrase a steady increase in behaviors fairly represents these minimal changes. R58 has been very pleasant during LSW□s follow-up visits and no changes have been noted that would validate the results of the 6/22/16 PHQ-9 score.	

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F 250	Continued From page 2 3/23/16 did not identify diagnosis of depression and anxiety, indicated severe cognitive impairment with a Brief interview for Mental Status (BIMS) score of four without symptoms of delirium or behaviors. The MDS included a PHQ-9 score of 3 and identified R58 had not reported feelings of being better off dead, however felt tired and had little energy nearly every day. The MDS identified use of antipsychotic and anti-depressant medications. R58's quarterly MDS dated 6/22/16 included and identified diagnosis of depression and dementia with behavioral disturbance, use of antipsychotic and anti-depressant medications. The MDS also identified severe cognitive impairment with a BIMS score of zero. The assessment now reflected fluctuating delirium signs and symptoms of inattention and disorganized thinking as well as physical behavioral symptoms directed towards others 1 to 3 days during the assessment period. The PHQ-9 reflected a substantial increase in depressive symptoms with a score of fifteen indicating major depression or moderately severe. The PHQ-9 reported R58 now had thoughts of being better off dead half or more of the days during the look back period, had little interest or pleasure in doing things nearly every day, feeling tired nearly every day, and feeling down, depressed, and hopeless half or more of the days. R58's physician order dated 4/11/16 included decrease Mirtazapine (anti-depressant medication) to 15 mg every bedtime. R58's behavioral progress notes reviewed from 4/1/16-6/27/16. Progress notes reported delusional behavior patterns such as resident reporting someone in her room and they were going to kill her and reports of other people being in her room. Behavioral progress note dated	F 250	No other residents were identified as having a significant increase in a PHQ-9 score without follow-up. If there is an increase in score on the PHQ-9 that moves a resident to a different level (there are a total of 5 levels) of depression, the LSW will notify the Clinical Managers and DON of this change. The LSW will check with nursing staff about any changes in observed behavior and will document their impressions in a progress note. The LSW will talk to a family member to notify them of the change in PHQ-9 score and to determine if the family has noted any changes in the resident□s mood or behaviors. The LSW will make a follow-up visit to the resident within one week of the increased PHQ-9 score and document her observations of the resident□s mood/behaviors. When notified of an increase in level of depression, as measured by the PHQ-9, the CM will review the resident□s medications and behavioral charting. CM or designee will notify the physician, who will decide if any change in treatment is warranted. The LSW and CM will determine if there is a need for increased visits from Social Services or if a referral for psychiatric services should be considered. The Risk Management Committee will continue to review target behaviors at least monthly during its weekly meetings.	

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F 250	Continued From page 3 5/11/16 reflected a steady increase in target behavior of "accusing staff of lying to her" from January through April 2016. R58's physician visit progress note dated 5/17/16 included, "Nursing staff indicates no new problems. Her husband recently died, which she does not remember." Physician note identified depression likely to be mild. Physician progress note indicated R58 had weight loss likely related to dementia however, physician indicated the Divalproex (mood altering medication) was decreased from 125 milligrams (mg) three times a day to 125 mg twice per day related to weight loss as a possible adverse drug reaction. R58's social services note dated 6/22/16, at 11:35 a.m. included, "RE [regarding] mood: Today's PHQ-9 score of (15) does show a significant decline in mood, simply for the fact that she was so vocal during our visit with how she feels. [R58] was able to stay on task and respond to every one of the items re mood, and with quite detailed responses. She readily admitted to little/no interest in doing things (d/t [due to] poor eyesight/hearing per her comment), frequently frustrated & depressed, occasional insomnia, tired on a daily basis, feeling bad about herself, difficulty concentrating, and thoughts re better off dead. "They can just throw a sheet over me and wait for me to die" was her exact response. She denied any potential for self-harm when asked, and went on to state "that just isn't me." "[R58] has likely had these feelings over the past several months, but per recent resident interviews, she has consistently denied them when specifically asked. [R58] continues to spend a good majority of her time resting in bed. This is per her choice, has been baseline for well over the past year, but not worse or more often this review. Despite sx's [symptoms] present, [R58] can be quite pleasant	F 250	The DON will review the records of those residents who have been identified as having a change in level of depression as measured by the PHQ-9 to determine if follow-up was completed as described. She will present the results of her audits at the next two Quality Assurance Committee meetings. A decision as to the need for continued audits will be made at that time.	

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F 250	Continued From page 4 to visit with, and does well when provided personal attention. No additional issues at this time. Will continue to monitor for potential changes in cognition & mood and address prn [as needed]." R58's record lacked a comprehensive assessment following the substantial increase in depressive mood symptoms and of statements of feeling better off dead in the last quarter even though R58's spouse had died, there had been a decrease in two mood altering medications and increase in delusional and physical behavior patterns. The record further lacked documentation of physician notification. R58's current care plan provided by the facility on 6/30/16 identified potential for mood alteration related to depression, anxiety, and dementia. The care plan identified the increase of mood score of 15 that indicated moderate depression. The care plan indicated R58 reported little to no interest in things, had sadness/frustration, occasional insomnia, was tired daily, feels bad about self and had made comments of being better off dead without a plan. The care plan identified R58 preferred to be in bed when not visiting with family. R58's care plan identified and included interventions last dated 11/19/14 to manage mood alterations as: · contact medical doctor as needed · facilitate appointment with psych and/or mental services as needed · monitor efficacy and adverse consequences of medications, · monitor for changes/decline in mood and address as needed. · Will evaluate, monitor, intervene or counsel as appropriate/necessary. R58's care plan and record lacked evidence the	F 250		

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F 250	Continued From page 5	F 250		

care plan had been updated after the change in mood score from four to fifteen.
During an interview on 6/9/16, at 9:06 a.m. nursing assistant (NA)-D stated we try to get R58 out of bed as often as we can and she stays in bed because she is tired or has pain. NA-D explained to surveyor she was not aware of increase in depressive symptoms or had recently made comments that she felt she would be better off dead, however was aware R58's husband had recently passed away and indicated R58 was not aware of that. NA-D explained R58 since admission liked to be in her room and in bed a lot, however she did not do a lot of wondering.
During an interview on 6/29/16, at 9:19 a.m. licensed practical nurse (LPN)-C stated R58 was not one to come out of her room since time of admission. LPN-C stated staff try to get her out of her room as much as possible. LPN-C stated she was not aware R58 had recently expressed feelings she would be better off dead or the increase in depressive symptoms. LPN-C indicated she had not personally seen an increase in depressive symptoms and was not aware if or how social services was involved. LPN-C explained if there was an increase in symptoms then nursing would document in the medical record, notify the physician and family members to see if therapy services were needed.
During an interview on 6/29/16, at 9:25 a.m. activities assistant (AA)-A stated R58 benefited from 1:1 visits in her room and was provided sensory one to one visits. AA-A stated she was not aware of the recent increase in depressive symptoms and R58's feelings of being better off dead.
During an interview on 6/29/16, at 9:30 a.m. with licensed social worker (LSW) stated she had notified the nurse manager of the increase in the

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F 250	Continued From page 6 PHQ-9 score, and stated, "I don't know that I implemented anything" as a result of the increase in score showing worsening depression. LSW explained the increase in symptoms could have been situational. LSW stated she had written a detailed progress note, updated the care plan to include PHQ-9 score changes, and had implemented the intervention of continue to monitor. LSW reported, "To me interventions are things that you can try they are not solutions, whether they work or not." LSW stated the family had not been updated of the change in mood status and would be updated today (6/29/16) at the scheduled care conference. LSW explained the PHQ-9 score could change from day to day depending on how R58 was feeling at the time of assessment, however LSW stated she had not made any follow-up visits since the time of the PHQ-9 assessment on 6/22/16. LSW explained residents psychosocial needs are met through social services visits but explained that visits were not based on if the residents received psychotropic medications. In response to the question, "How do you manage mood symptoms?" LSW stated, "We don't manage her mood she has a right to be angry or sad. You just have to take the time to redirect or reassure and find if something is going on." LSW reported, an outside referral for mental health services had not been considered or addressed following the increase in depression symptoms or the statements of being better off dead. During an interview on 6/29/16, at 9:48 a.m. NA-E reported she was not aware of any increase in depressive symptoms or R58's feelings of being better off dead. During an interview on 6/29/16, at 9:51 a.m. LPN-A reported she was not aware of R58's feeling of being better off dead and was not	F 250		

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F 250	Continued From page 7 aware of the increase in depressive symptoms. During an interview on 6/29/16, at 12:00 p.m. registered nurse (RN)-A indicated she had not been made aware of the mood status as reported by the social worker. RN-A stated LSW had reported the change this morning (6/29/16) to her. RN-A explained the EHR (electronic health record) system identifies changes on assessments by sending out warning messages of need for further assessment and intervention. RN-A stated a warning message was created as a result of the increase in the PHQ-9 score on 6/22/16, however the social worker had signed the warning, indicating the alert was addressed and follow-up was completed. RN-A stated, if she had been alerted of the mood change score either by the EHR warning or verbal communication she would have completed a comprehensive mood assessment to determine the possible root cause of the increase in depressive symptoms, notify the physician of the findings as well as direct care staff, and develop and implement immediate interventions. RN-A explained the process is the same regardless if the resident has dementia and/or memory impairments, the mood change needs to be addressed. During an interview on 6/29/16, at 12:23 p.m. director of nursing (DON) stated the changes of the score on the PHQ-9 should have been addressed and reported immediately and interventions put into place. DON stated, it should have been followed up on. A facility policy pertaining providing social services was requested and not received. Facility policy Medication Management Policy, included necessary requirements for assessment and care plan revision based on evaluations performed by nursing staff to justify the use of	F 250		

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F 250	Continued From page 8 continued medications. The policy did not address procedures for increases in depressive symptoms.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		7/21/16

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(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 272	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facilty failed to comprehensively assess missing/broken teeth for 1 of 3 residents (R7) reviewed for dental. Findings include: R7's Admission Record indicated an admission date of 3/26/15. Admission Care & Assessment Plan dated 3/26/15 oral status revealed "some missing teeth." Admission Minimum Data Set (MDS) dated 4/2/15 indicated no dental concerns. Annual MDS dated 3/10/16 indicated no dental concerns. On 6/30/16 at 10:04 a.m. R7 stated he had three or four broken and missing teeth. R7 denied any problems chewing and stated he was independent with his dental cares. On 6/30/16 at 12:57 p.m. registered nurse (RN)-A, a nurse manager, was interviewed regarding R7's MDS dental assessments. "That was an error on my part. I will add it to his care plan. Every quarter in the care conference we address if he has any concerns. He did not have any concerns or want to see the dentist." Facility Assessment and Care Plan System Policy dated 1/5/16 reads, "It is the policy of Sacred Heart Care Center to provide a comprehensive	F 272	It is the practice of Sacred Heart Care Center to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity and to make a comprehensive assessment of a resident□s NEEDS using the RAI. As stated, R7□s Admission Assessment noted that R7 had some missing teeth. Also, as stated, on 6/30/16, R7 denied any problems chewing and stated he was independent with dental care, facts that supported the indication of no dental concerns on his MDS. As with all residents, R7 is asked at each care conference if he has any dental concerns or would like to schedule a dental appointment. R7 has always responded no to these questions. Clinical Managers, who perform assessments and develop care plans, have been informed that missing teeth must be included even if there is no problem or need associated with them. Clinical Managers will make a visual inspection of the mouths of all residents on their wings by 7/21/2016 and review individual assessments and care plans to ensure that missing/broken teeth are	

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F 272	Continued From page 10 interdisciplinary assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental, and psychosocial functioning possible. This comprehensive assessment in turn is used to develop and individualize a comprehensive plan of care."	F 272	included. CM□s will follow this practice for each new admission and during comprehensive assessments thereafter. DON will audit the assessments and care plans of three new admissions to determine if missing or broken teeth noted on the nursing admission assessment are also included on the RAI and care plan. She will report audit results at the October QA meeting. A determination will be made at that time if additional audits are needed.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		7/21/16

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F 279	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to care plan missing teeth for 1 of 3 residents (R51) reviewed for dental status. Findings include: On 6/27/16, at 3:18 p.m., observation revealed R51 had two missing teeth on the left side of his mouth (one on the top gum line and one on the bottom gum line). R51's facility Admission Assessment, dated 2/3/14, identified oral status, some missing teeth. R51's Nursing Assessment dated 4/27/16, oral/dental status failed to identify missing teeth. R51's care plan, print date 6/29/16, identified self-care deficit dressing, bathing, grooming related to weakness, impaired sitting, standing balance, ability varies day to day, needs supervision and verbal cues. Diagnoses of anxiety, cognitive impairment, anemia, neuropathy, cataract, macular degeneration and legal blindness. Resident and family prefer only as needed dental appointments. Facilitate dental appointments as resident/family request. Resident brushes own teeth after set up. On 6/28/16, at 2:56 p.m., registered nurse (RN)-A stated she was responsible for completing the oral assessments and does visually look in the resident's mouth at the time the assessment is completed. RN-A stated she was not aware R51 had missing teeth. RN-A reviewed R51's facility Admission Assessment, dated 2/3/14, and confirmed the assessment identified R51 had	F 279	It is the practice of Sacred Heart Care Center to develop a comprehensive care plan for each resident that includes measurable objectives and timetable to meet a resident□s medical, nursing, and mental and psychosocial NEEDS that are identified in the comprehensive assessment. R51 has had no problems or needs associated with his missing teeth. As stated in the deficiency, the care plan does include his dental preference: Resident and family prefer only as-needed dental appointments. Clinical Managers, who perform assessments and develop care plans, have been informed that missing teeth must be included even if there is no problem or need associated with them. Clinical Managers will make a visual inspection of the mouths of all residents on their wings by 7/21/2016 and review individual assessments and care plans to ensure that missing/broken teeth are included. CM□s will follow this practice for each new admission and during comprehensive assessments thereafter. DON will audit the assessments and care plans of three new admissions to determine if missing or broken teeth noted on the nursing admission assessment are also included on the RAI and care plan. She will report audit results at the October QA meeting. A determination will be	

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F 279	Continued From page 12 some missing teeth and R51's Nursing Assessment dated 4/27/16, oral/dental status failed to identify missing teeth. At 3:16 p.m., RN-A observed R51's teeth and confirmed, on the left side of R51's mouth, R51 had one missing tooth on the top gum line and bottom gum line. RN-A confirmed R51's care plan failed to include missing teeth. On 6/29/16, at 1:15 p.m., the director of nursing stated if missing teeth was identified on the assessment and if an issue with the resident then missing teeth should be on the care plan. The facility Assessment and Care Plan System-Care Plan and Conference-Interdisciplinary, dated 1/5/16, indicated Procedure 5. The care plan team is to assure that the following areas are addressed and/or care planned. Completed by the facilitator. e. Overall physical status.	F 279	made at that time if additional audits are needed.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		7/27/16

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F 280	Continued From page 13 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan to include anxiety symptoms treated with medication and ongoing monitoring and target anxiety behaviors, goals with individualized interventions for 1 of 5 residents (R5) reviewed for unnecessary medications. Findings included: R5's facility admission record included diagnosis of anxiety disorder. R5's quarterly Minimum Data Set (MDS) dated 3/20/16 included diagnoses of anxiety disorder and demonstrated fluctuating behaviors of inattention, severe cognitive impairment with a Brief Interview for Mental Status score of four. The MDS reported R5 was administered anti-anti-anxiety medications every day during the look-back period. R5's current printed physician's orders provided by the facility on 6/30/16 included Alprazolam 0.25 milligram (mg) by mouth as needed (PRN) for anxiety up to daily for anxiety or dyspnea (shortness of breath); the order reflected a start date of 3/23/16. The orders further reflected the PRN order for Alprazolam was increased to give 0.25 mg every night for anxiety or dyspnea on 5/11/16. Physician's order also included Buspirone 15 mg twice a day for anxiety with a start date of 3/31/16.	F 280	Diagnosis of anxiety with monitoring per facility policy was added to R5's Care Plan on 6/28/2016, during the survey. Clarification was received from the physician that Alprazolam is given for dyspnea. Clinical Managers will continue to review all Care Plans at least quarterly and make revisions as needed. Consulting Pharmacist will continue to do routine med reviews for all residents. Risk Management Committee will continue to review psychotropic medications for all residents monthly and as needed. In conjunction with each care plan review and care conference during the months of August and September, each Clinical Manager will note if the resident(s) they are reviewing is currently taking a psychotropic medication and if so, will verify that the Care Plan accurately reflects an appropriate diagnosis and behavioral symptoms and management for that resident. They will report the results of these audits at the October QA Committee meeting. The QA Committee will determine at that time if there is a	

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F 280	Continued From page 14 R5's Medication Administration Record for May and June 2016 reflected nightly administration of Alprazolam 0.25 mg (nightly after 5/11/16)and twice-daily administration of Buspirone 15 mg. R5's current care plan provided by the facility on 6/30/16 did not identify diagnosis of anxiety and lacked a plan of care for anxiety target behavior monitoring and interventions for symptom management. The care plan also lacked identification of monitoring and management of prescribed anti-anxiety medications. During observations on 6/27/16, at 3:27 p.m. R5 was resting in her bed with her eyes closed. During an observations on 6/28/16 at 8:42 a.m. and at 1:26 p.m. R5 was sitting quietly in her wheelchair. During an interview on 6/28/16, at 2:20 p.m. director of nursing (DON) reviewed R5's care plan and indicated there was not a plan of care for anxiety and stated there should be one. DON stated R5's care plan would be updated today. Facility policy Medication Management Policy last reviewed 2/7/16 included, "Information gathered during the initial and ongoing evaluations are incorporated into a comprehensive care plan that reflects appropriate medication-related goals and parameters for monitoring the resident's condition and ongoing need for medication(s), including, but not limited to, what is monitored, who will be responsible fro monitoring, and how often and when a re-evaluation is necessary." Facility policy Psychotropic Medication Policy and Procedure included, "Medications use is not the sole approach for behavioral intervention. Other interventions will be identified in the care plan."	F 280	need for additional audits.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		7/29/16

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F 281	Continued From page 15 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete facial grooming as directed in the initial care plan for 1 of 1 resident (R70) reviewed for activities of daily living. Findings include: R70 had been observed on 6/27/16, at 2:53 p.m. and 6/28/16, at 1:47 p.m. R70 had long grey and black facial hair on the left side of her chin. R70 admitted to the facility on 6/8/16 with diagnoses of dementia, macular degeneration, and optic atrophy, according to the facility admission record. R70's Admission Assessment and Care Plan dated 6/8/16 informed staff resident needed glasses for both distance and reading and indicated R70 reported vision is worse at times related to macular degeneration. The assessment informed R70 had activities of daily living limitations and had a self care deficit. During an interview on 6/28/16, at 1:32 p.m. licensed practical nurse (LPN)-B indicated if residents do not have their own razors we contact family to bring one in for them. LPN-B reported the facility had a community razor that was available if the resident did not have one. During an interview on 6/28/16, at 1:39 p.m. NA-B stated R70's bath days were on Sundays and Thursday evenings. NA-B stated R70 was completely independent and puts on her light when she needs help. NA-B stated she would set	F 281	R70 was described as independent with cares. NA-C immediately removed the hair from R70□s chin when it was made known to her that the resident wanted it removed. However, NA-C described the process as using a tweezers to remove three hairs from the resident□s chin, none of which exceeded one-fourth inch in length □ not really consistent with the deficiency description as long grey and black facial hair. A razor was purchased for R70. Nursing Assistant meetings will be held during the week of July 25-29 and nursing assistants will be reeducated on the need to monitor facial hair, even if the resident is otherwise independent. The QA Coordinator, or her designee, will audit facial grooming for at least one resident on each wing weekly for four weeks (does not have to be the same residents each week). If grooming does not meet a professional standard, the responsible nursing assistant will be directed to offer additional grooming to the resident, including removal of chin hairs. QA Coordinator will report results of audits at the first QA meeting following the completion of the audits. Need for continued audits will be determined at that meeting.	

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F 281	Continued From page 16	F 281		

up her wash clothes in her bathroom sink for her. NA-B explained if residents have facial hair, families need to bring in razors or if they have one or two strands then we just pluck them out. NA-B stated if residents did not have their own razors then we notify the nurse and they call the family. NA-B went on to explain if the family is not around or they do not bring a razor in then we would notify social services to see if there is any money in their account to get one. NA-B stated then if there was not money in the account then it should be documented in the record why the resident was not shaved. NA-B reported the facility did not have a community razor because of infection control purposes and possibility of cross contamination between residents.

During an observation and interview on 6/28/16, at 1:52 p.m. NA-C indicated residents facial hair is removed everyday with cares. NA-C brought R70 back to her room from the dining room area. NA-C reported the hair on R70's chin should be removed if R70 wanted it to be removed. NA-C asked R70 if she had a razor. R70 indicated her husband usually removed the facial hair with a tweezers. R70 stated she was not able to see the facial hair because of her vision and did not want the facial hair to be there and wanted someone to remove it. NA-C then removed the facial hair.

During an interview on 6/29/16, at 12:45 p.m. director of nursing (DON) stated, the facility does not have a community razor for infection control purposes and we request family members provide the razors. DON explained if the family did not bring one in then facility would check the resident account. DON explained shaving preferences should be included in the care plan, staff should follow the care plan, and if the

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F 281	Continued From page 17 resident was not shaved the reason should be documented in the record.	F 281		
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 record review, the facility failed to complete facial hair grooming as care planned for 1 of 1 resident (R5) observed for activities of daily living. Findings include: R5 had been observed on 6/27/16, at 3:27 p.m. and 6/28/16, at 8:42 a.m. R5 had long thin black/grey facial hair on her chin and upper lip. R5's quarterly Minimum Data Set (MDS) dated 3/30/16 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4 and extensive physical assist from two staff members for personal hygiene. R5's care plan included R5 had a self-care deficit in areas of dressing, bathing, and grooming related to mild cognitive impairment. The care plan directed, "staff shave resident." During an interview on 6/28/16, at 1:26 p.m. nursing assistant (NA)-C reported R5's shower days were Thursday evenings, and indicated R5	F 282	As stated by LPN-B, facility had contacted R5□s son multiple times to request a razor for the purpose of removing facial hair from resident. (Facility does not have a razor for use on multiple residents.) Son had stated R5 had always had facial hair and it didn□t bother her. He did, however, bring a razor to the facility on 6/30/2016 and it is being used as needed. Previously, he would sometimes bring a razor with him during a visit and would shave his mother himself. He did not, however, leave the razor at the facility for daily use. Nursing Assistant meetings will be held during the week of July 25-29 and nursing assistants will be reeducated on the steps to take if a resident does not have a razor for facial grooming. Applicable facility policies have been updated to include recognition of shaving preferences and procedures. The QA Coordinator, or her designee, will	7/29/16

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F 282	Continued From page 18 could wash her face, and arms. NA-C stated "We take care of nails and facial hair." NA-C stated residents should be checked for facial hair every day. NA-C stated it looked like R5 had not been shaved in a while and needed to be done. NA-C explained the facility has attempted for family to bring in a razor. NA-C reported she thought the facility had a community razor. During an interview on 6/28/16, at 1:32 p.m. licensed practical nurse (LPN)-B indicated if residents do not have their own razors we contact family to bring one in for them. LPN-B reported the facility had a community razor that was available if the resident did not have one. LPN-B reported multiple attempts had been made for family to bring in working razors. During an interview on 6/29/16, at 12:45 p.m. director of nursing (DON) stated, the facility does not have a community razor for infection control purposes and we request family members provide the razors. DON explained if the family did not bring one in then facility would check the resident account. DON explained shaving preferences should be included in the care plan, staff should follow the care plan, and if the resident was not shaved the reason should be documented in the record. Facility policy Activities of Daily Living (Daily Life Functions) last reviewed on 1/5/16 included, "The purpose of activities of daily living is to provide assistance to resident for daily life functions. To supervise resident activities in order to maintain optimum functions as long as possible, and to re-educate in techniques of daily life function. The policy did not include requirements for ensuring shaving preferences or	F 282	audit personal grooming for at least one resident on each wing weekly for four weeks (does not have to be the same residents each week). If adequate grooming has not been completed, the responsible nursing assistant will be directed to offer additional grooming to the resident, including removal of chin hairs. The QA Coordinator will review the care plan and notify the Clinical Manager if shaving preference was not included on the care plan. QA Coordinator will report results of audits at the first QA meeting following the completion of the audits. The need for continued audits will be determined at that meeting.	

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F 282	Continued From page 19 procedures." Facility policies AM (Morning) Care, HS (bedtime) Cares, and Hair Care did not include requirements for ensuring shaving preferences or procedures.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide hygiene assistants for a dependent resident according to the care plan for 1 of 1 resident (R5) reviewed for activities of daily living. Findings included: R5 had been observed on 6/27/16, at 3:27 p.m. and 6/28/16, at 8:42 a.m. R5 had long thin black/grey facial hair on her chin and upper lip. R5's quarterly Minimum Data Set (MDS) dated 3/30/16 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4 and extensive physical assist from two staff members for personal hygiene. R5's care plan included R5 had a self-care deficit in areas of dressing, bathing, and grooming	F 312	As stated by NA-C, facility had contacted R5□s son multiple times to request a razor for the purpose of removing facial hair from resident. (Facility does not have a razor for use on multiple residents.) Son had stated R5 had always had facial hair and it didn□t bother her. He did, however, bring a razor to the facility on 6/30/2016 and it is being used as needed. At meetings on 7/20/2016, nurses were reeducated on procedures to take if a resident is in need of a razor and were reminded that there is no such thing as a "community razor." They were also informed to contact the Clinical Manager or DON if families do not respond to requests for a razor. Applicable facility policies have been updated to include recognition of shaving preferences and	7/29/16

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F 312	Continued From page 20 related to mild cognitive impairment. The care plan directed, "staff shave resident." During an interview on 6/28/16, at 1:26 p.m. nursing assistant (NA)-C reported R5's shower days were Thursday evenings, and indicated R5 could wash her face, arms and underneath her breasts. NA-C stated "we take care of nails and facial hair." NA-C stated residents should be checked for facial hair every day. NA-C stated it looked like R5 had not been shaved in a while and needed to be done. NA-C explained the facility has attempted for family to bring in a razor. NA-C reported she thought the facility had a community razor. During an interview on 6/29/16, at 12:45 p.m. director of nursing (DON) stated, the facility does not have a community razor for infection control purposes and we request family members provide the razors. DON explained if the family did not bring one in then facility would check the resident account. DON explained shaving preferences should be included in the care plan, staff should follow the care plan, and if the resident was not shaved the reason should be documented in the record. Facility policy Activities of Daily Living (Daily Life Functions) last reviewed on 1/5/16 included, "The purpose of activities of daily living is to provide assistance to resident for daily life functions. To supervise resident activities in order to maintain optimum functions as long as possible, and to re-educate in techniques of daily life function. The policy did not include requirements for ensuring shaving preferences or procedures."	F 312	procedures. Nursing Assistant meetings will be held during the week of July 25-29 and nursing assistants will be reeducated on thorough grooming practices, the steps to take if a resident does not have a razor for facial grooming, and will be reminded that there is no such thing as a "community razor." The QA Coordinator, or her designee, will audit the care plan and personal appearance of at least one resident from each wing weekly for the next four weeks (does not have to be the same residents each week) to determine if facial grooming is being completed as care-planned. If not, the responsible nursing assistant will be directed to offer facial grooming to the resident. The QA Coordinator will review the care plan and notify the Clinical Manager if shaving preference was not included on the care plan. QA Coordinator will report results of audits at the first QA meeting following the completion of the audits. The need for continued audits will be determined at that meeting.	

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F 312	Continued From page 21 Facility policies AM (Morning) Care, HS (bedtime) Cares, and Hair Care did not include requirements for ensuring shaving preferences or procedures.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify specific target behaviors to determine efficacy for the use of an	F 329	R57□s target behavior of making suicidal comments was being monitored by nurses and Risk Management Committee.	7/19/16

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F 329	Continued From page 22 antianxiety and antipsychotic medications for 1 of 5 residents (R57) reviewed for unnecessary medications. Findings include: R57's admission record, dated, 9/25/2014, indicated that the resident had diagnoses of post-traumatic stress disorder, major depressive disorder, mild cognitive impairment, panic disorder, dependent personality disorder and generalized anxiety disorder. R57's physician orders, dated, 8/27/15 indicated that the resident had been prescribed Risperidone (an antipsychotic medication) 2 mg (milligrams) to be taken by mouth at bedtime related to major depressive disorder. In addition, R57 had been prescribed Lorazepam (an antianxiety medication), dated 11/13/15. She was to take 0.5 mg by mouth three times a day related to generalized anxiety. R57's quarterly Minimum Data Set (MDS), dated 2/24/16, indicated that the resident was cognitively intact. R57's psychoactive medication assessment, dated 5/24/16, indicated that the resident was taking 0.5 mg of Ativan three times a day in addition to Risperdal 2 mg every evening. It stated that she suffered from major depression and generalized anxiety. It stated that her behaviors consisted of statements of sadness and anxiety, crying and not sleeping. In summary, it stated that R57 had long term problems with mental illness and use of psychotropic medications. It recommended to continue to monitor the efficacy of the medications. It stated	F 329	Communication to nursing assistants of target behavior for R57 and documentation by nurses has been improved by adding target behavior for R57 to the electronic Point of Care (completed every shift by NA□s) and the electronic Medication Administration Record (completed every shift by nurses). On 7/12/16, target behavior for R57 was changed to hallucinations. The Psychotropic Medication Policy was reviewed and updated by several members of the Risk Management Committee. The Risk Management Committee will continue to monitor target behaviors, gradual dose reductions, and psychotropic medication use for all residents at least monthly. These have been reviewed for all residents to ensure appropriate identification of target behaviors Clinical Manager RN-B will monitor documentation of target behaviors weekly until the next Quality Assurance Committee meeting. Results will be reported and a determination will be made by the committee as to the continued need for audits.	

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that R57 was readmitted back to the facility on 8/27/15 with new orders for Risperdal. R57 did not have any suicidal comments this month. It recommended to continue to same plan of care.

R57's medication administration record (MAR), reviewed from 6/1/13 through 6/30/16, indicated that the resident had been taking the Ativan and Risperdal as prescribed.

R57's care plan, dated 10/3/2014, stated that the resident had a potential for altered mood related to diagnoses of anxiety, depression, panic and dependent personality disorder. R57 had a lengthy psychological history with prior hospital stays in a behavioral healthcare unit and had a history of electroconvulsive treatment along with suicidal ideation. R57 was followed by mental health which R57 reported as beneficial. R57 had a history of tongue thrusting and sucking and thrusting the lower lip. The care plan encouraged the staff to monitor R57 for changes and declines in her mood and address them as needed. The care plan also recommended to monitor her psychological medication as directed by the facility policy. It advised to question R57 about hallucinations, delusions, wanting to die and if she had a plan to commit suicide.

R57's doctor's progress note, dated 6/6/2016, stated that the resident remained fragile psychiatrically which contributed to difficult psychopharmatherapuetic management. It stated that something must be done about R57's polypharmacy.

When interviewed on 6/29/2016 at 1:19 p.m., R57 was asked which types of behaviors she exhibited when she became anxious. She stated

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that when she was anxious she tended to isolate herself from human company.

When interviewed on 6/29/16 at 1:32 p.m. nursing assistant (NA)-F was asked what target behaviors and mood symptoms she had been instructed to notify the nurses in order to document. NA-F stated that R57 would get very angry if someone were to call her a man. NA-F stated that R57 did not get along with a previous roommate and would say things but that had been resolved. When asked if R57 did tend to isolate herself, NA-F stated that R57 did have a tendency to isolate herself a lot. NA-F stated that she saw R57 isolate herself once or twice a week. When asked if R57 had any hallucinations, NA-F stated no but stated a couple months ago when R57 had gone to the hospital she was seeing things and talking to herself.

When interviewed on 6/30/16 at 10:18 a.m., NA-G was asked what target behaviors she had been instructed to notify the nursing staff in order to document. NA-G stated that R57 did not have any behaviors that she knew of to report. NA-G stated that she did not report any behaviors as R57 did not exhibit any. When asked if R57 tended to isolate herself, NA-G denied that R57 isolated herself. When asked if R57 had any hallucinations or delusions, NA-G denied that as well.

When interviewed on 6/30/16 at 10:28 a.m., NA-H stated that she had never seen R57 exhibit any behaviors such as isolation or hallucinations or delusions. NA-H stated that she had never heard that R57 was suicidal or had expressed thoughts of killing herself. NA-H stated that R57 seemed calm and did not tend to isolate herself.

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F 329	Continued From page 25 When interviewed on 6/30/16 at 10:35 a.m., registered nurse (RN)-B stated that R57's psychiatrist had prescribed both the Ativan and the Risperdal. R57's primary care physician did not prescribe these medications. RN-B was asked what specific target behaviors the nursing staff had been monitoring for to determine if the two medications were affective or not. RN-B stated R57 had been monitored for making suicidal comments. RN-B stated that R57 had started on Risperdal back in August 2015 when she had been in the hospital. RN-B stated that the Ativan had not been something that R57 was just prescribed. RN-B stated that R57 had been on the medication prior to coming to the facility. When asked what resident centered behaviors of anxiety R57 had exhibited RN-B stated that R57 would make frequent repetitive health complaints which was due to her anxiety. When interviewed on 6/30/16 at 12:30 p.m., RN- stated that R57 had never exhibited psychotic features. She stated when R57 had been placed on Risperdal and came back to the facility, the interdisciplinary team (IDT) had reviewed her behaviors. She stated at the time the only thing that R57 had exhibited was that one time R57 had made a suicidal comment and so the nursing staff had started monitoring for that. When interviewed on 6/30/16 at 2:32 p.m., the director of nursing (DON) was informed of the lack of mood and behavior monitoring. The DON said that they should have been identified and monitored. Review of the Psychotropic Medication Policy and Procedure, last reviewed on 2/6/2014, it stated	F 329		

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F 329	Continued From page 26 that each resident's drug regimen must be free from unnecessary medications. It identified unnecessary drugs as any medication used without adequate monitoring. When antipsychotic medication was initiated, it stated that the resident was monitored to determine the effectiveness of the medication. Behaviors were to be documented on the behavior documenting sheet.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334		7/21/16

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F 334	Continued From page 27 The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by:	F 334		

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F 334	Continued From page 28 Based on interview and document review, the facility failed to ensure 5 of 5 residents (R43, R12, R38, R4 and R35) was offered and/or received the 13-valent pneumococcal conjugate vaccine (PCV13) vaccination as recommended by Centers for Disease Control (CDC). Findings include: R43's Admission Record, dated 1/6/2015, indicated that the resident had a diagnosis of Alzheimer's disease. R43's Immunization Report, dated historically (11/27/2001), indicated that the resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) but not the PCV13. R12's Admission Record, dated 5/3/2010, indicated that the resident had diagnoses of Alzheimer's disease and chronic obstructive pulmonary disease (COPD). R12's Immunization Report, dated 5/7/2011, indicated that the resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) but not the PCV13. R38's Admission Record, dated 3/2/2012, indicated that the resident had a diagnosis of mild cognitive impairment. R38's Immunization Report, dated historically (12/1/2009), indicated that the resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) but not the PCV13.	F 334	As noted, all identified residents had received the 23-valent pneumococcal polysaccharide vaccine and there had been initial discussion of the need to offer the PCV13 vaccine. R43, R12, R38, R4, and R35 (or responsible parties) have now received information about the 13-valent pneumococcal conjugate vaccine and have completed a written form indicating their preference in regard to receiving the PCV13 vaccine. If their preference is to receive PCV13, that information will be passed on to their primary physician, who will be responsible for determining the timing of the vaccination according to CDC recommendations and for giving the order for the vaccination. The immunization records of all residents will be reviewed in conjunction with their next scheduled physician visit. Information about PCV13, if the resident has not yet received it, will be given to responsible parties by the Rounds Nurse when she gives notification to them of the date of the next scheduled physician visit. The form indicating acceptance or declination of PCV13 must be completed before the physician can address it. The Director of Nursing will compile a list of existing residents who have not received the PCV13 vaccine and give the information to the Rounds Nurse for further action as described above. New residents will receive this information at admission. The DON or Infection Control list will report the number of residents as	

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F 334	Continued From page 29 R4's Admission Record, dated 10/26/2015, indicated that the resident had diagnoses of dementia and cardiomyophathy. R4's Immunization Report, dated historically (4/1/2002), indicated that the resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23). R4 received a second PPSV23 on 12/15/2009 but not the PCV13. R35's Admission Record, dated 11/11/2014, indicated that the resident had diagnoses of: diabetes, heart failure and chronic kidney disease. R35's Immunization Report, dated historically (11/1/2011), indicated that the resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) but not the PCV13. When interviewed on 6/30/16 at 2:37 p.m., the director of nursing stated that she started hearing about the new requirements to offer the PCV13 vaccine to residents last year. She stated that she had not yet begun to push the policy yet but the Medical Director had begun talking about it. She stated that they haven't begun instituting offering it yet but it was going to be in the works.	F 334	well as how many are accepting or declining PCV13 at, at least, the next two quarterly Infection Control/Safety meetings. The need for continued reporting will be determined at the second meeting.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		7/21/16

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F 441	Continued From page 30 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to track and trend ongoing infections to determine if staff education was necessary to prevent infections. This included review of R35 who had an infection recorded on the April 2016	F 441	Facility would like to note that cellulitis is a non-contagious condition and posed no potential threat to other residents, staff, or visitors.	

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F 441	Continued From page 31 infection log. This had the potential to effect all residents, staff and visitors. Findings include: R35 was included on the April 2016 infection log with diagnosis of Cellulitis. Documentation included antibiotic of Bactrim DS give one for ten days. Start date 4/5/16 and end date 4/15/2016. no other information found on log. No indication if antibiotic was affective and if cellulitis had cleared. There was no indication if education of staff was given due to lack of trending. Review of the facility's Monthly Infection Report for All Nursing Units for April, May and June 2016 contained a total amount of infections for each month. Infections were color coded on a map of the facility which identified which wing each infection was located. An order listing report for all three months only indicated residents who had received antibiotics, indication for use of antibiotics, and start and stop dates of the antibiotics. The infection control logs lacked all residents who had an infection that was not treated with an antibiotic, an overall assessment of infection trends and lacked identification of facility acquired infections. In addition, the logs did not reflect documentation of preventative measures to stop or reduce the risk for spread of infections that had occurred in the facility during April, May and June 2016. When interviewed on 6/30/2016 at 2:08 p.m., the infection control nurse, (LPN)-A stated that residents were monitored when they were placed on antibiotics. She stated that the infection should have resolved when they were given the last dose of medication. She stated that the staff should be	F 441	Facility uses colored coded map of facility to assist in tracking infections and identifying if clusters of infections exist. Supervisory staff are given morning report daily including information related to number, types and locations of infections present in the facility, whether or not the resident is receiving an antibiotic. Based on this information a determination may be made to increase hand washing audits, to provide additional education to staff, or to contact Medical Director regarding possible need for quarantine. Nurses complete infection notes in the progress notes when a resident is receiving an antibiotic. The facility has multiple policies in place related to infection control, such as hand-washing, universal precautions, procedures for cleaning and disinfecting equipment, etc. The Infection Control nurse also does observations of nursing assistants performing cares to monitor infection control procedures. In addition to continuing these practices, the DON will maintain an infection log, tracking all infections and documenting the assessment of trends or the need for preventative measures. The Administrator will review the log before the next quarterly Infection Control meeting and will discuss with the DON what changes, if any, might be made. The DON will report on the progress and any problems or challenges with the log at the next Infection Control meeting and the	

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F 441	Continued From page 32 writing in an infection note whether the infection was resolved or not. A copy was requested of the facility's policy regarding tracking and trending infections.	F 441	next quarterly Quality Assurance meeting.	
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical director, or	F 520	It has proven difficult at times for the Medical Director to attend all QA meetings	7/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	06/30/2016

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
F 520	Continued From page 33 designated physician, attended quality assessment and assurance (QAA) meetings for 3 of 4 quarterly QAA meetings. Findings include: Review of the facility's QAA meeting attendance records, reviewed from 7/13/15 to 4/11/16, revealed the medical director attended the QAA meeting held on 7/13/15 and not again until 4/11/16 (a period of nine months). The attendance records revealed no physician attended the QAA meetings held on 9/28/15, 11/9/15 and 1/18/16. On 6/30/16, at 2:07 p.m., quality assurance coordinator (QAC)-B confirmed the medical director had not attended the QAA meetings as required quarterly. The QAC-B stated the facility tried to coordinate the meetings for when the medical director was in the facility for rounds so he can be present. The QAC-B stated no other physician was present in place of the medical director. The QAC-B stated she was aware the Medical Director was not attending the meetings. The facility policy, undated, indicated the following individuals will serve on the committee: Medical Director. The committee will meet at least quarterly.	F 520	since his time to see residents and accomplish other tasks is limited. However, he reads the Minutes from any meeting he was not able to attend and is easily contacted for input about any quality issues. After the survey, the QA Coordinator contacted the Medical Director to develop a plan to improve his attendance at QA meetings. This involves more communication regarding his scheduled time in Austin and the possibility of his attending through Skype if necessary.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245447 Y1	A. Building B. Wing Y2	8/13/2016 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0250	Correction	ID Prefix	F0272	Correction	ID Prefix	F0279	Correction
Reg. #	483.15(g)(1)	Completed	Reg. #	483.20(b)(1)	Completed	Reg. #	483.20(d), 483.20(k)(1)	Completed
LSC		07/19/2016	LSC		07/21/2016	LSC		07/21/2016
ID Prefix	F0280	Correction	ID Prefix	F0281	Correction	ID Prefix	F0282	Correction
Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(i)	Completed	Reg. #	483.20(k)(3)(ii)	Completed
LSC		07/27/2016	LSC		07/29/2016	LSC		07/29/2016
ID Prefix	F0312	Correction	ID Prefix	F0329	Correction	ID Prefix	F0334	Correction
Reg. #	483.25(a)(3)	Completed	Reg. #	483.25(l)	Completed	Reg. #	483.25(n)	Completed
LSC		07/29/2016	LSC		07/19/2016	LSC		07/21/2016
ID Prefix	F0441	Correction	ID Prefix	F0520	Correction	ID Prefix		Correction
Reg. #	483.65	Completed	Reg. #	483.75(o)(1)	Completed	Reg. #		Completed
LSC		07/21/2016	LSC		07/19/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 9/14/2016	SIGNATURE OF SURVEYOR 10160	DATE 8/13/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/30/2016	☐ YES ☐ NO

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 1395

September 14, 2016

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

Subject: Sacred Heart Care Center
Provider # 245447
Project # S5447026

Dear Ms. Mathews Halverson:

This is in response to your letter received on July 21, 2016, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tag F441 where corresponding correction orders were issued pursuant to the survey completed on June 30, 2016.

The information presented with your letter, the CMS and State 2567s dated June 30, 2016, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

State Tag ID 2-1380 : Subp. 2. Direction of program. A nursing home must assign one person, either a registered nurse or a physician, the responsibility of directing infection control activities in the nursing home.

Summary of the facility's reason for IDR of this tag:
The facility indicated they maintain an efficient Infection Control Program that reflects trending and analysis of data collected to reduce the risk of infection transmission. The facility indicated that although they have not formalized their processes for documenting specific infection trending and analysis patterns, their systems function. The facility also asserts this deficiency is not a systems issue as evidenced by only one resident having been identified in the deficiency.

Summary of Findings:

The facility provided printout documents during the survey which indicated which resident(s) had received antibiotic(s) from April 1, 2016 through June 30, 2016, with the corresponding diagnoses for the antibiotic use.

The facility had provided documents during the survey which indicated which units (facility map) had residents who had experienced infections. The infections identified on the facility map dated April 2016 through June 2016, included urinary tract infections, upper respiratory infections, skin, gastrointestinal and other. A review of the form revealed only the date of the infection, the room the resident with the infection was located in, and inconsistently documented the diagnoses for the antibiotic use.

The facility provided a third form, Monthly Infection Report for Individual Nursing Units from April 2016 through June 30, 2016. The form identified the name of the resident, date of infection, whether the infection was nosocomial or not, diagnosis, infection site, symptoms, culture/pathogen, treatment and medication orders, and remarks/interventions. The form for Wing 1 identified two residents with an infection. However, the facility map identified seven residents who had experienced an infection. Wing 2 identified one resident with an infection however, the map identified five resident who had experienced infections. Wing 3 documentation indicated no residents with an infection however, the corresponding map identified six residents with an infection. The April form was inconsistent regarding documentation of whether infections were nosocomial or not, what symptoms were present, culture/pathogens, treatment and medication orders, and remarks/interventions. In addition a note on the Wing 1 report for the month of May 2016, indicated the facility was to utilize the printout form and add a section to identify which bacteria were present and the infection site. However, the forms the facility provided for May and June 2016, failed to include either. In addition, all three forms lacked monitoring and/or documentation of infections, including tracking and analyzing outbreaks of infection, as well as implementing and documenting actions to resolve related problems.

The facility's policy and procedure for Infection Control was requested but was not provided.

Conclusion:

The facility failed to ensure the infection control program included all components including: planning, organizing, implementing, operating, monitoring and maintaining all elements of the program in order to ensure the facility's interdisciplinary team was involved in infection prevention and control. The facility did not have a current program in place that included surveillance, including process and outcome surveillance, monitoring, data analysis, documentation and communicable disease reporting.

This is a valid deficiency at this tag and at the correct Scope and Severity of F (Widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy).

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-3792 Fax: 651-215-9697

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gary Nederhoff, Rochester District Office Unit Supervisor

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LKO9

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 **08/13/2016** (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
X 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
	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):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 08/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 08/16/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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 (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245447

August 16, 2016

Ms. Rebecca Mathews Halverson, Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, MN 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 July 29, 2016 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 16, 2016

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

RE: Project Number S5447026 and H5447008

Dear Ms. Mathews Halverson:

On July 11, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 30, 2016 that included an investigation of complaint number H5447008. This survey found the most serious deficiencies to bewidespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 13, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 25, 2016 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 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 29, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 30, 2016, effective July 29, 2016 and therefore remedies outlined in our letter to you dated July 11, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245447 Y1	A. Building B. Wing Y2	8/13/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0250	Correction	ID Prefix F0272	Correction	ID Prefix F0278	Correction
Reg. # 483.15(g)(1)	Completed	Reg. # 483.20(b)(1)	Completed	Reg. # 483.20(g) - (j)	Completed
LSC	07/19/2016	LSC	07/21/2016	LSC	07/21/2016
ID Prefix F0279	Correction	ID Prefix F0280	Correction	ID Prefix F0281	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(i)	Completed
LSC	07/21/2016	LSC	07/27/2016	LSC	07/29/2016
ID Prefix F0282	Correction	ID Prefix F0312	Correction	ID Prefix F0329	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(l)	Completed
LSC	07/29/2016	LSC	07/29/2016	LSC	07/19/2016
ID Prefix F0334	Correction	ID Prefix F0441	Correction	ID Prefix F0520	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.65	Completed	Reg. # 483.75(o)(1)	Completed
LSC	07/21/2016	LSC	07/21/2016	LSC	07/19/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	8/16/2016	10160	8/13/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/30/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245447 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/25/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 07/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 8/16/2016	SIGNATURE OF SURVEYOR 37008	DATE 7/25/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/29/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LKO9

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: **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 **06/30/2016** (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

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
	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):

17. SURVEYOR SIGNATURE Date : 7/27/2016 (L19)
Danette Bakken HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date: 08/15/2016 (L20)
Kamala Fiske-Downing, Health Program Representative

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

19. DETERMINATION OF ELIGIBILITY
____ 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 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 11, 2016

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

RE: Project Number S5447026 and Complaint number H5447008

Dear Ms. Mathews-Halverson:

On June 30, 2016, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 30, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5447008 that was found to be unsubstantiated.

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;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at**

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 August 9, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 9, 2016 the following remedy will be imposed:

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

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 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 ePoC 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. 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 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.

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 September 30, 2016 (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 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

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
	245447	A. BUILDING _____ B. WING _____	06/30/2016

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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation were also completed at the time of the standard survey. The investigation of complaint H5447008 was completed and found not to be substantiated.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess mood changes after a substantial increase in depressive symptoms for 1 of 5 residents (R58) reviewed for unnecessary medications.	F 250	It is the practice of Sacred Heart Care Center to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.	7/19/16

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

Electronically Signed | 07/21/2016

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

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F 250	Continued From page 1 Findings included: R58 had been observed on 6/27/16, at 3:07 p.m., 6/28/16, at 9:03 a.m., and 6/29/16 at 11:00 a.m. R58 was lying in bed awake. During an interview on 6/29/16, at 8:58 a.m. while R58 was lying in bed awake. In response to the question, "I noticed you stay in your room, is there a reason you like to be alone?" R58 stated, "I don't know where to go or what to do and when I talk to people they look at me like I'm a stupid idiot." R58 stated sometimes she feels sad. R58 was then asked, "How do staff help you with your depression?" R58 responded, "I suppose they talk to me about it, but I don't know how often." After several more minutes of conversation, R58's sentence structure was not comprehendible for meaning. R58 had diagnoses of dementia with behavioral disturbance, major depressive disorder, restlessness and agitation, anxiety disorder, and abnormal weight loss according to the facility admission record. R58's last Care Area Assessment performed on 12/29/15 included, "PHQ-9 [a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression] score of (04) remains low. She consistently admits to feeling tired (almost all the time) and having occasional down/sad days but denied difficulty with any of the remaining items. Current medication therapy for her depression remains beneficial [Celexa, Mirtazapine, Divalproex for migraines but also used to control mood, and Quetiapine]. No additional issues or concerns with this review. Will continue to monitor for potential changes in cognition and mood and address PRN [as needed]." R58's quarterly Minimum Data Set (MDS) dated	F 250	Another PHQ-9 was administered to R58 on 6/29/16 with a resulting score of 10. RN-A also initiated behavioral charting on every shift for R58. The physician was notified on 6/29/16 of the four most recent scores on the PHQ-9. He expressed that the PHQ-9 is not a valid assessment instrument for nursing home residents with dementia, noting that staff observations are much better indicators of mood. He will see the resident on 7/19/2016 and determine at that time if any treatment changes are warranted. The family was notified of the change in the PHQ-9 scores on 6/29/16 as well as the fact that nursing had not reported anything different about R58□s behaviors. Daughter stated that family had also not seen any change in mood. The behavioral progress note dated 5/11/16 stated in its entirety: The target behavior we are monitoring is □Accusing staff of lying to her.□ In the month of January, the target behavior did not occur. In the month of February, again, the target behavior did not occur. In the month of March, the target behavior did occur x 1 and the month of April it occurred x 3. Facility does not agree that the phrase a steady increase in behaviors fairly represents these minimal changes. R58 has been very pleasant during LSW□s follow-up visits and no changes have been noted that would validate the results of the 6/22/16 PHQ-9 score.	

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F 250	Continued From page 2 3/23/16 did not identify diagnosis of depression and anxiety, indicated severe cognitive impairment with a Brief interview for Mental Status (BIMS) score of four without symptoms of delirium or behaviors. The MDS included a PHQ-9 score of 3 and identified R58 had not reported feelings of being better off dead, however felt tired and had little energy nearly every day. The MDS identified use of antipsychotic and anti-depressant medications. R58's quarterly MDS dated 6/22/16 included and identified diagnosis of depression and dementia with behavioral disturbance, use of antipsychotic and anti-depressant medications. The MDS also identified severe cognitive impairment with a BIMS score of zero. The assessment now reflected fluctuating delirium signs and symptoms of inattention and disorganized thinking as well as physical behavioral symptoms directed towards others 1 to 3 days during the assessment period. The PHQ-9 reflected a substantial increase in depressive symptoms with a score of fifteen indicating major depression or moderately severe. The PHQ-9 reported R58 now had thoughts of being better off dead half or more of the days during the look back period, had little interest or pleasure in doing things nearly every day, feeling tired nearly every day, and feeling down, depressed, and hopeless half or more of the days. R58's physician order dated 4/11/16 included decrease Mirtazapine (anti-depressant medication) to 15 mg every bedtime. R58's behavioral progress notes reviewed from 4/1/16-6/27/16. Progress notes reported delusional behavior patterns such as resident reporting someone in her room and they were going to kill her and reports of other people being in her room. Behavioral progress note dated	F 250	No other residents were identified as having a significant increase in a PHQ-9 score without follow-up. If there is an increase in score on the PHQ-9 that moves a resident to a different level (there are a total of 5 levels) of depression, the LSW will notify the Clinical Managers and DON of this change. The LSW will check with nursing staff about any changes in observed behavior and will document their impressions in a progress note. The LSW will talk to a family member to notify them of the change in PHQ-9 score and to determine if the family has noted any changes in the resident□s mood or behaviors. The LSW will make a follow-up visit to the resident within one week of the increased PHQ-9 score and document her observations of the resident□s mood/behaviors. When notified of an increase in level of depression, as measured by the PHQ-9, the CM will review the resident□s medications and behavioral charting. CM or designee will notify the physician, who will decide if any change in treatment is warranted. The LSW and CM will determine if there is a need for increased visits from Social Services or if a referral for psychiatric services should be considered. The Risk Management Committee will continue to review target behaviors at least monthly during its weekly meetings.	

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F 250	Continued From page 3 5/11/16 reflected a steady increase in target behavior of "accusing staff of lying to her" from January through April 2016. R58's physician visit progress note dated 5/17/16 included, "Nursing staff indicates no new problems. Her husband recently died, which she does not remember." Physician note identified depression likely to be mild. Physician progress note indicated R58 had weight loss likely related to dementia however, physician indicated the Divalproex (mood altering medication) was decreased from 125 milligrams (mg) three times a day to 125 mg twice per day related to weight loss as a possible adverse drug reaction. R58's social services note dated 6/22/16, at 11:35 a.m. included, "RE [regarding] mood: Today's PHQ-9 score of (15) does show a significant decline in mood, simply for the fact that she was so vocal during our visit with how she feels. [R58] was able to stay on task and respond to every one of the items re mood, and with quite detailed responses. She readily admitted to little/no interest in doing things (d/t [due to] poor eyesight/hearing per her comment), frequently frustrated & depressed, occasional insomnia, tired on a daily basis, feeling bad about herself, difficulty concentrating, and thoughts re better off dead. "They can just throw a sheet over me and wait for me to die" was her exact response. She denied any potential for self-harm when asked, and went on to state "that just isn't me." "[R58] has likely had these feelings over the past several months, but per recent resident interviews, she has consistently denied them when specifically asked. [R58] continues to spend a good majority of her time resting in bed. This is per her choice, has been baseline for well over the past year, but not worse or more often this review. Despite sx's [symptoms] present, [R58] can be quite pleasant	F 250	The DON will review the records of those residents who have been identified as having a change in level of depression as measured by the PHQ-9 to determine if follow-up was completed as described. She will present the results of her audits at the next two Quality Assurance Committee meetings. A decision as to the need for continued audits will be made at that time.	

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F 250	Continued From page 4 to visit with, and does well when provided personal attention. No additional issues at this time. Will continue to monitor for potential changes in cognition & mood and address prn [as needed]." R58's record lacked a comprehensive assessment following the substantial increase in depressive mood symptoms and of statements of feeling better off dead in the last quarter even though R58's spouse had died, there had been a decrease in two mood altering medications and increase in delusional and physical behavior patterns. The record further lacked documentation of physician notification. R58's current care plan provided by the facility on 6/30/16 identified potential for mood alteration related to depression, anxiety, and dementia. The care plan identified the increase of mood score of 15 that indicated moderate depression. The care plan indicated R58 reported little to no interest in things, had sadness/frustration, occasional insomnia, was tired daily, feels bad about self and had made comments of being better off dead without a plan. The care plan identified R58 preferred to be in bed when not visiting with family. R58's care plan identified and included interventions last dated 11/19/14 to manage mood alterations as: · contact medical doctor as needed · facilitate appointment with psych and/or mental services as needed · monitor efficacy and adverse consequences of medications, · monitor for changes/decline in mood and address as needed. · Will evaluate, monitor, intervene or counsel as appropriate/necessary. R58's care plan and record lacked evidence the	F 250		

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F 250	Continued From page 5	F 250		

care plan had been updated after the change in mood score from four to fifteen.
During an interview on 6/9/16, at 9:06 a.m. nursing assistant (NA)-D stated we try to get R58 out of bed as often as we can and she stays in bed because she is tired or has pain. NA-D explained to surveyor she was not aware of increase in depressive symptoms or had recently made comments that she felt she would be better off dead, however was aware R58's husband had recently passed away and indicated R58 was not aware of that. NA-D explained R58 since admission liked to be in her room and in bed a lot, however she did not do a lot of wondering.
During an interview on 6/29/16, at 9:19 a.m. licensed practical nurse (LPN)-C stated R58 was not one to come out of her room since time of admission. LPN-C stated staff try to get her out of her room as much as possible. LPN-C stated she was not aware R58 had recently expressed feelings she would be better off dead or the increase in depressive symptoms. LPN-C indicated she had not personally seen an increase in depressive symptoms and was not aware if or how social services was involved. LPN-C explained if there was an increase in symptoms then nursing would document in the medical record, notify the physician and family members to see if therapy services were needed.
During an interview on 6/29/16, at 9:25 a.m. activities assistant (AA)-A stated R58 benefited from 1:1 visits in her room and was provided sensory one to one visits. AA-A stated she was not aware of the recent increase in depressive symptoms and R58's feelings of being better off dead.
During an interview on 6/29/16, at 9:30 a.m. with licensed social worker (LSW) stated she had notified the nurse manager of the increase in the

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F 250	Continued From page 6	F 250		

PHQ-9 score, and stated, "I don't know that I implemented anything" as a result of the increase in score showing worsening depression. LSW explained the increase in symptoms could have been situational. LSW stated she had written a detailed progress note, updated the care plan to include PHQ-9 score changes, and had implemented the intervention of continue to monitor. LSW reported, "To me interventions are things that you can try they are not solutions, whether they work or not." LSW stated the family had not been updated of the change in mood status and would be updated today (6/29/16) at the scheduled care conference. LSW explained the PHQ-9 score could change from day to day depending on how R58 was feeling at the time of assessment, however LSW stated she had not made any follow-up visits since the time of the PHQ-9 assessment on 6/22/16. LSW explained residents psychosocial needs are met through social services visits but explained that visits were not based on if the residents received psychotropic medications. In response to the question, "How do you manage mood symptoms?" LSW stated, "We don't manage her mood she has a right to be angry or sad. You just have to take the time to redirect or reassure and find if something is going on." LSW reported, an outside referral for mental health services had not been considered or addressed following the increase in depression symptoms or the statements of being better off dead.

During an interview on 6/29/16, at 9:48 a.m. NA-E reported she was not aware of any increase in depressive symptoms or R58's feelings of being better off dead.

During an interview on 6/29/16, at 9:51 a.m. LPN-A reported she was not aware of R58's feeling of being better off dead and was not

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(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 250	Continued From page 7 aware of the increase in depressive symptoms. During an interview on 6/29/16, at 12:00 p.m. registered nurse (RN)-A indicated she had not been made aware of the mood status as reported by the social worker. RN-A stated LSW had reported the change this morning (6/29/16) to her. RN-A explained the EHR (electronic health record) system identifies changes on assessments by sending out warning messages of need for further assessment and intervention. RN-A stated a warning message was created as a result of the increase in the PHQ-9 score on 6/22/16, however the social worker had signed the warning, indicating the alert was addressed and follow-up was completed. RN-A stated, if she had been alerted of the mood change score either by the EHR warning or verbal communication she would have completed a comprehensive mood assessment to determine the possible root cause of the increase in depressive symptoms, notify the physician of the findings as well as direct care staff, and develop and implement immediate interventions. RN-A explained the process is the same regardless if the resident has dementia and/or memory impairments, the mood change needs to be addressed. During an interview on 6/29/16, at 12:23 p.m. director of nursing (DON) stated the changes of the score on the PHQ-9 should have been addressed and reported immediately and interventions put into place. DON stated, it should have been followed up on. A facility policy pertaining providing social services was requested and not received. Facility policy Medication Management Policy, included necessary requirements for assessment and care plan revision based on evaluations performed by nursing staff to justify the use of	F 250		

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	245447	A. BUILDING _____ B. WING _____	06/30/2016

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F 250	Continued From page 8 continued medications. The policy did not address procedures for increases in depressive symptoms.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		7/21/16

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F 272	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facilty failed to comprehensively assess missing/broken teeth for 1 of 3 residents (R7) reviewed for dental. Findings include: R7's Admission Record indicated an admission date of 3/26/15. Admission Care & Assessment Plan dated 3/26/15 oral status revealed "some missing teeth." Admission Minimum Data Set (MDS) dated 4/2/15 indicated no dental concerns. Annual MDS dated 3/10/16 indicated no dental concerns. On 6/30/16 at 10:04 a.m. R7 stated he had three or four broken and missing teeth. R7 denied any problems chewing and stated he was independent with his dental cares. On 6/30/16 at 12:57 p.m. registered nurse (RN)-A, a nurse manager, was interviewed regarding R7's MDS dental assessments. "That was an error on my part. I will add it to his care plan. Every quarter in the care conference we address if he has any concerns. He did not have any concerns or want to see the dentist." Facility Assessment and Care Plan System Policy dated 1/5/16 reads, "It is the policy of Sacred Heart Care Center to provide a comprehensive	F 272	It is the practice of Sacred Heart Care Center to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity and to make a comprehensive assessment of a resident□s NEEDS using the RAI. As stated, R7□s Admission Assessment noted that R7 had some missing teeth. Also, as stated, on 6/30/16, R7 denied any problems chewing and stated he was independent with dental care, facts that supported the indication of no dental concerns on his MDS. As with all residents, R7 is asked at each care conference if he has any dental concerns or would like to schedule a dental appointment. R7 has always responded no to these questions. Clinical Managers, who perform assessments and develop care plans, have been informed that missing teeth must be included even if there is no problem or need associated with them. Clinical Managers will make a visual inspection of the mouths of all residents on their wings by 7/21/2016 and review individual assessments and care plans to ensure that missing/broken teeth are	

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F 272	Continued From page 10 interdisciplinary assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental, and psychosocial functioning possible. This comprehensive assessment in turn is used to develop and individualize a comprehensive plan of care."	F 272	included. CM□s will follow this practice for each new admission and during comprehensive assessments thereafter. DON will audit the assessments and care plans of three new admissions to determine if missing or broken teeth noted on the nursing admission assessment are also included on the RAI and care plan. She will report audit results at the October QA meeting. A determination will be made at that time if additional audits are needed.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278		7/21/16

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F 278	Continued From page 11 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to code the Minimum Data Set (MDS) accurately for toileting for 1 of 3 residents (R18) reviewed for activities of daily living (ADL). Findings include: R18's quarterly MDS, dated 1/13/16, had identified for toileting R18 required extensive assist. R18's quarterly MDS, dated 4/13/16, identified R18 required limited assist with toileting. On 6/29/16, at 7:24 a.m., R18 was sitting in a rocking chair in his room and was observed to have a urinary catheter leg bag secured to his right lower extremity and nursing assistant (NA)-A stated she had emptied urine from R18's catheter leg bag and was to empty R18's catheter leg bag every two hours. At 9:33 a.m., NA-A was observed to provide hands on assistance for R18 with toileting. NA-A assisted pulling down and up R18's pants and emptied urine from R18's catheter leg bag. On 6/29/16, at 9:52 a.m., registered nurse (RN)-A stated she was responsible for coding R18's MDS. RN-A stated staff providing the care of emptying a catheter leg bag would be extensive assist. RN-A confirmed staff were providing	F 278	This deficiency was based on one coding error on one MDS. The nurse responsible for completing the noted MDS was well-aware that when nursing assistants are providing catheter care to a resident, toileting on the MDS should be coded as “extensive assist.” The coding as “limited assist” was simply an error on her part and was not done willfully or knowingly. The facility was unable to identify any residents who need “protection” from a single miscoding such as this. The cited deficiency portrayed the resident as needing less assistance than he actually needed so if it led to a rate change, it would have been to the detriment of the facility. The facility has recently updated its electronic records capability to allow nursing assistants to chart the assistance they are providing at the point of care. This information feeds directly into the MDS, allowing less room for error or miscoding. Clinical Managers will continue to accurately complete MDS’s. The facility has an excellent record with Case Mix Annual Review, with zero changes to levels of care for the past two	

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F 278	Continued From page 12 toileting assist of emptying R18's catheter leg bag during the assessment period for R18's MDS dated 4/13/16. RN-A confirmed R18's MDS dated 4/13/16, was coded as limited assist and should have been coded as extensive assist. On 6/29/16, at 1:17 p.m., the director of nursing stated staff providing catheter care (emptying a catheter leg bag) was extensive assist and if staff were documenting the assist provided inaccurately, the person completing the MDS would verify the assist provided and document a note for verification of accuracy. A facility policy Minimum Data Set, dated revised 6/6/14, was provided, however the policy failed to address accuracy of coding the MDS.	F 278	years. The facility will continue to use that review as an indicator of coding accuracy. Results from that review will be presented at the first QA Committee meeting following the review. Based on those results, the Committee will determine if Clinical Managers need more education about completing the MDS or if an in-house monitoring system needs to be put in place. The facility policy “Minimum Data Set” has been reviewed and updated to include: “The assessment…will accurately reflect the functional capacity of the resident at the time."	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		7/21/16

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F 279	Continued From page 13 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to care plan missing teeth for 1 of 3 residents (R51) reviewed for dental status. Findings include: On 6/27/16, at 3:18 p.m., observation revealed R51 had two missing teeth on the left side of his mouth (one on the top gum line and one on the bottom gum line). R51's facility Admission Assessment, dated 2/3/14, identified oral status, some missing teeth. R51's Nursing Assessment dated 4/27/16, oral/dental status failed to identify missing teeth. R51's care plan, print date 6/29/16, identified self-care deficit dressing, bathing, grooming related to weakness, impaired sitting, standing balance, ability varies day to day, needs supervision and verbal cues. Diagnoses of anxiety, cognitive impairment, anemia, neuropathy, cataract, macular degeneration and legal blindness. Resident and family prefer only as needed dental appointments. Facilitate dental appointments as resident/family request. Resident brushes own teeth after set up. On 6/28/16, at 2:56 p.m., registered nurse (RN)-A stated she was responsible for completing the oral assessments and does visually look in the resident's mouth at the time the assessment is	F 279	It is the practice of Sacred Heart Care Center to develop a comprehensive care plan for each resident that includes measurable objectives and timetable to meet a resident□s medical, nursing, and mental and psychosocial NEEDS that are identified in the comprehensive assessment. R51 has had no problems or needs associated with his missing teeth. As stated in the deficiency, the care plan does include his dental preference: Resident and family prefer only as-needed dental appointments. Clinical Managers, who perform assessments and develop care plans, have been informed that missing teeth must be included even if there is no problem or need associated with them. Clinical Managers will make a visual inspection of the mouths of all residents on their wings by 7/21/2016 and review individual assessments and care plans to ensure that missing/broken teeth are included. CM□s will follow this practice for each new admission and during comprehensive assessments thereafter. DON will audit the assessments and care plans of three new admissions to determine if missing or broken teeth noted	

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F 279	Continued From page 14 completed. RN-A stated she was not aware R51 had missing teeth. RN-A reviewed R51's facility Admission Assessment, dated 2/3/14, and confirmed the assessment identified R51 had some missing teeth and R51's Nursing Assessment dated 4/27/16, oral/dental status failed to identify missing teeth. At 3:16 p.m., RN-A observed R51's teeth and confirmed, on the left side of R51's mouth, R51 had one missing tooth on the top gum line and bottom gum line. RN-A confirmed R51's care plan failed to include missing teeth. On 6/29/16, at 1:15 p.m., the director of nursing stated if missing teeth was identified on the assessment and if an issue with the resident then missing teeth should be on the care plan. The facility Assessment and Care Plan System-Care Plan and Conference-Interdisciplinary, dated 1/5/16, indicated Procedure 5. The care plan team is to assure that the following areas are addressed and/or care planned. Completed by the facilitator. e. Overall physical status.	F 279	on the nursing admission assessment are also included on the RAI and care plan. She will report audit results at the October QA meeting. A determination will be made at that time if additional audits are needed.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280		7/27/16

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F 280	Continued From page 15 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan to include anxiety symptoms treated with medication and ongoing monitoring and target anxiety behaviors, goals with individualized interventions for 1 of 5 residents (R5) reviewed for unnecessary medications. Findings included: R5's facility admission record included diagnosis of anxiety disorder. R5's quarterly Minimum Data Set (MDS) dated 3/20/16 included diagnoses of anxiety disorder and demonstrated fluctuating behaviors of inattention, severe cognitive impairment with a Brief Interview for Mental Status score of four. The MDS reported R5 was administered anti-anti-anxiety medications every day during the look-back period. R5's current printed physician's orders provided by the facility on 6/30/16 included Alprazolam 0.25 milligram (mg) by mouth as needed (PRN) for anxiety up to daily for anxiety or dyspnea (shortness of breath); the order reflected a start date of 3/23/16. The orders further reflected the PRN order for Alprazolam was increased to give	F 280	Diagnosis of anxiety with monitoring per facility policy was added to R5's Care Plan on 6/28/2016, during the survey. Clarification was received from the physician that Alprazolam is given for dyspnea. Clinical Managers will continue to review all Care Plans at least quarterly and make revisions as needed. Consulting Pharmacist will continue to do routine med reviews for all residents. Risk Management Committee will continue to review psychotropic medications for all residents monthly and as needed. In conjunction with each care plan review and care conference during the months of August and September, each Clinical Manager will note if the resident(s) they are reviewing is currently taking a psychotropic medication and if so, will verify that the Care Plan accurately reflects an appropriate diagnosis and behavioral symptoms and management	

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F 280	Continued From page 16 0.25 mg every night for anxiety or dyspnea on 5/11/16. Physician's order also included Buspirone 15 mg twice a day for anxiety with a start date of 3/31/16. R5's Medication Administration Record for May and June 2016 reflected nightly administration of Alprazolam 0.25 mg (nightly after 5/11/16)and twice-daily administration of Buspirone 15 mg. R5's current care plan provided by the facility on 6/30/16 did not identify diagnosis of anxiety and lacked a plan of care for anxiety target behavior monitoring and interventions for symptom management. The care plan also lacked identification of monitoring and management of prescribed anti-anxiety medications. During observations on 6/27/16, at 3:27 p.m. R5 was resting in her bed with her eyes closed. During an observations on 6/28/16 at 8:42 a.m. and at 1:26 p.m. R5 was sitting quietly in her wheelchair. During an interview on 6/28/16, at 2:20 p.m. director of nursing (DON) reviewed R5's care plan and indicated there was not a plan of care for anxiety and stated there should be one. DON stated R5's care plan would be updated today. Facility policy Medication Management Policy last reviewed 2/7/16 included, "Information gathered during the initial and ongoing evaluations are incorporated into a comprehensive care plan that reflects appropriate medication-related goals and parameters for monitoring the resident's condition and ongoing need for medication(s), including, but not limited to, what is monitored, who will be responsible fro monitoring, and how often and when a re-evaluation is necessary." Facility policy Psychotropic Medication Policy and Procedure included, "Medications use is not the sole approach for behavioral intervention. Other interventions will be identified in the care plan."	F 280	for that resident. They will report the results of these audits at the October QA Committee meeting. The QA Committee will determine at that time if there is a need for additional audits.	

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete facial grooming as directed in the initial care plan for 1 of 1 resident (R70) reviewed for activities of daily living. Findings include: R70 had been observed on 6/27/16, at 2:53 p.m. and 6/28/16, at 1:47 p.m. R70 had long grey and black facial hair on the left side of her chin. R70 admitted to the facility on 6/8/16 with diagnoses of dementia, macular degeneration, and optic atrophy, according to the facility admission record. R70's Admission Assessment and Care Plan dated 6/8/16 informed staff resident needed glasses for both distance and reading and indicated R70 reported vision is worse at times related to macular degeneration. The assessment informed R70 had activities of daily living limitations and had a self care deficit. During an interview on 6/28/16, at 1:32 p.m. licensed practical nurse (LPN)-B indicated if residents do not have their own razors we contact family to bring one in for them. LPN-B reported the facility had a community razor that was available if the resident did not have one. During an interview on 6/28/16, at 1:39 p.m. NA-B stated R70's bath days were on Sundays and Thursday evenings. NA-B stated R70 was	F 281	R70 was described as independent with cares. NA-C immediately removed the hair from R70□s chin when it was made known to her that the resident wanted it removed. However, NA-C described the process as using a tweezers to remove three hairs from the resident□s chin, none of which exceeded one-fourth inch in length □ not really consistent with the deficiency description as long grey and black facial hair. A razor was purchased for R70. Nursing Assistant meetings will be held during the week of July 25-29 and nursing assistants will be reeducated on the need to monitor facial hair, even if the resident is otherwise independent. The QA Coordinator, or her designee, will audit facial grooming for at least one resident on each wing weekly for four weeks (does not have to be the same residents each week). If grooming does not meet a professional standard, the responsible nursing assistant will be directed to offer additional grooming to the resident, including removal of chin hairs. QA Coordinator will report results of audits at the first QA meeting following the completion of the audits. Need for continued audits will be determined at that meeting.	7/29/16

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F 281	Continued From page 18	F 281		

completely independent and puts on her light when she needs help. NA-B stated she would set up her wash clothes in her bathroom sink for her. NA-B explained if residents have facial hair, families need to bring in razors or if they have one or two strands then we just pluck them out. NA-B stated if residents did not have their own razors then we notify the nurse and they call the family. NA-B went on to explain if the family is not around or they do not bring a razor in then we would notify social services to see if there is any money in their account to get one. NA-B stated then if there was not money in the account then it should be documented in the record why the resident was not shaved. NA-B reported the facility did not have a community razor because of infection control purposes and possibility of cross contamination between residents.

During an observation and interview on 6/28/16, at 1:52 p.m. NA-C indicated residents facial hair is removed everyday with cares. NA-C brought R70 back to her room from the dining room area. NA-C reported the hair on R70's chin should be removed if R70 wanted it to be removed. NA-C asked R70 if she had a razor. R70 indicated her husband usually removed the facial hair with a tweezers. R70 stated she was not able to see the facial hair because of her vision and did not want the facial hair to be there and wanted someone to remove it. NA-C then removed the facial hair.

During an interview on 6/29/16, at 12:45 p.m. director of nursing (DON) stated, the facility does not have a community razor for infection control purposes and we request family members provide the razors. DON explained if the family did not bring one in then facility would check the resident account. DON explained shaving

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F 281	Continued From page 19 preferences should be included in the care plan, staff should follow the care plan, and if the resident was not shaved the reason should be documented in the record.	F 281		
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 record review, the facility failed to complete facial hair grooming as care planned for 1 of 1 resident (R5) observed for activities of daily living. Findings include: R5 had been observed on 6/27/16, at 3:27 p.m. and 6/28/16, at 8:42 a.m. R5 had long thin black/grey facial hair on her chin and upper lip. R5's quarterly Minimum Data Set (MDS) dated 3/30/16 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4 and extensive physical assist from two staff members for personal hygiene. R5's care plan included R5 had a self-care deficit in areas of dressing, bathing, and grooming related to mild cognitive impairment. The care plan directed, "staff shave resident." During an interview on 6/28/16, at 1:26 p.m.	F 282	As stated by LPN-B, facility had contacted R5□s son multiple times to request a razor for the purpose of removing facial hair from resident. (Facility does not have a razor for use on multiple residents.) Son had stated R5 had always had facial hair and it didn□t bother her. He did, however, bring a razor to the facility on 6/30/2016 and it is being used as needed. Previously, he would sometimes bring a razor with him during a visit and would shave his mother himself. He did not, however, leave the razor at the facility for daily use. Nursing Assistant meetings will be held during the week of July 25-29 and nursing assistants will be reeducated on the steps to take if a resident does not have a razor for facial grooming. Applicable facility policies have been updated to include recognition of shaving preferences and procedures.	7/29/16

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F 282	Continued From page 20 nursing assistant (NA)-C reported R5's shower days were Thursday evenings, and indicated R5 could wash her face, and arms. NA-C stated "We take care of nails and facial hair." NA-C stated residents should be checked for facial hair every day. NA-C stated it looked like R5 had not been shaved in a while and needed to be done. NA-C explained the facility has attempted for family to bring in a razor. NA-C reported she thought the facility had a community razor. During an interview on 6/28/16, at 1:32 p.m. licensed practical nurse (LPN)-B indicated if residents do not have their own razors we contact family to bring one in for them. LPN-B reported the facility had a community razor that was available if the resident did not have one. LPN-B reported multiple attempts had been made for family to bring in working razors. During an interview on 6/29/16, at 12:45 p.m. director of nursing (DON) stated, the facility does not have a community razor for infection control purposes and we request family members provide the razors. DON explained if the family did not bring one in then facility would check the resident account. DON explained shaving preferences should be included in the care plan, staff should follow the care plan, and if the resident was not shaved the reason should be documented in the record. Facility policy Activities of Daily Living (Daily Life Functions) last reviewed on 1/5/16 included, "The purpose of activities of daily living is to provide assistance to resident for daily life functions. To supervise resident activities in order to maintain optimum functions as long as possible, and to re-educate in techniques of daily	F 282	The QA Coordinator, or her designee, will audit personal grooming for at least one resident on each wing weekly for four weeks (does not have to be the same residents each week). If adequate grooming has not been completed, the responsible nursing assistant will be directed to offer additional grooming to the resident, including removal of chin hairs. The QA Coordinator will review the care plan and notify the Clinical Manager if shaving preference was not included on the care plan. QA Coordinator will report results of audits at the first QA meeting following the completion of the audits. The need for continued audits will be determined at that meeting.	

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F 282	Continued From page 21 life function. The policy did not include requirements for ensuring shaving preferences or procedures." Facility policies AM (Morning) Care, HS (bedtime) Cares, and Hair Care did not include requirements for ensuring shaving preferences or procedures.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide hygiene assistants for a dependent resident according to the care plan for 1 of 1 resident (R5) reviewed for activities of daily living. Findings included: R5 had been observed on 6/27/16, at 3:27 p.m. and 6/28/16, at 8:42 a.m. R5 had long thin black/grey facial hair on her chin and upper lip. R5's quarterly Minimum Data Set (MDS) dated 3/30/16 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4 and extensive physical assist from two staff members for personal hygiene.	F 312	As stated by NA-C, facility had contacted R5□s son multiple times to request a razor for the purpose of removing facial hair from resident. (Facility does not have a razor for use on multiple residents.) Son had stated R5 had always had facial hair and it didn□t bother her. He did, however, bring a razor to the facility on 6/30/2016 and it is being used as needed. At meetings on 7/20/2016, nurses were reeducated on procedures to take if a resident is in need of a razor and were reminded that there is no such thing as a "community razor." They were also informed to contact the Clinical Manager or DON if families do not respond to requests for a razor. Applicable facility	7/29/16

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F 312	Continued From page 22 R5's care plan included R5 had a self-care deficit in areas of dressing, bathing, and grooming related to mild cognitive impairment. The care plan directed, "staff shave resident." During an interview on 6/28/16, at 1:26 p.m. nursing assistant (NA)-C reported R5's shower days were Thursday evenings, and indicated R5 could wash her face, arms and underneath her breasts. NA-C stated "we take care of nails and facial hair." NA-C stated residents should be checked for facial hair every day. NA-C stated it looked like R5 had not been shaved in a while and needed to be done. NA-C explained the facility has attempted for family to bring in a razor. NA-C reported she thought the facility had a community razor. During an interview on 6/29/16, at 12:45 p.m. director of nursing (DON) stated, the facility does not have a community razor for infection control purposes and we request family members provide the razors. DON explained if the family did not bring one in then facility would check the resident account. DON explained shaving preferences should be included in the care plan, staff should follow the care plan, and if the resident was not shaved the reason should be documented in the record. Facility policy Activities of Daily Living (Daily Life Functions) last reviewed on 1/5/16 included, "The purpose of activities of daily living is to provide assistance to resident for daily life functions. To supervise resident activities in order to maintain optimum functions as long as possible, and to re-educate in techniques of daily life function. The policy did not include requirements for ensuring shaving preferences or	F 312	policies have been updated to include recognition of shaving preferences and procedures. Nursing Assistant meetings will be held during the week of July 25-29 and nursing assistants will be reeducated on thorough grooming practices, the steps to take if a resident does not have a razor for facial grooming, and will be reminded that there is no such thing as a "community razor." The QA Coordinator, or her designee, will audit the care plan and personal appearance of at least one resident from each wing weekly for the next four weeks (does not have to be the same residents each week) to determine if facial grooming is being completed as care-planned. If not, the responsible nursing assistant will be directed to offer facial grooming to the resident. The QA Coordinator will review the care plan and notify the Clinical Manager if shaving preference was not included on the care plan. QA Coordinator will report results of audits at the first QA meeting following the completion of the audits. The need for continued audits will be determined at that meeting.	

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F 312	Continued From page 23 procedures." Facility policies AM (Morning) Care, HS (bedtime) Cares, and Hair Care did not include requirements for ensuring shaving preferences or procedures.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 329	R57□s target behavior of making suicidal	7/19/16

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F 329	Continued From page 24 review, the facility failed to identify specific target behaviors to determine efficacy for the use of an antianxiety and antipsychotic medications for 1 of 5 residents (R57) reviewed for unnecessary medications. Findings include: R57's admission record, dated, 9/25/2014, indicated that the resident had diagnoses of post-traumatic stress disorder, major depressive disorder, mild cognitive impairment, panic disorder, dependent personality disorder and generalized anxiety disorder. R57's physician orders, dated, 8/27/15 indicated that the resident had been prescribed Risperidone (an antipsychotic medication) 2 mg (milligrams) to be taken by mouth at bedtime related to major depressive disorder. In addition, R57 had been prescribed Lorazepam (an antianxiety medication), dated 11/13/15. She was to take 0.5 mg by mouth three times a day related to generalized anxiety. R57's quarterly Minimum Data Set (MDS), dated 2/24/16, indicated that the resident was cognitively intact. R57's psychoactive medication assessment, dated 5/24/16, indicated that the resident was taking 0.5 mg of Ativan three times a day in addition to Risperdal 2 mg every evening. It stated that she suffered from major depression and generalized anxiety. It stated that her behaviors consisted of statements of sadness and anxiety, crying and not sleeping. In summary, it stated that R57 had long term problems with mental illness and use of psychotropic	F 329	comments was being monitored by nurses and Risk Management Committee. Communication to nursing assistants of target behavior for R57 and documentation by nurses has been improved by adding target behavior for R57 to the electronic Point of Care (completed every shift by NA□s) and the electronic Medication Administration Record (completed every shift by nurses). On 7/12/16, target behavior for R57 was changed to hallucinations. The Psychotropic Medication Policy was reviewed and updated by several members of the Risk Management Committee. The Risk Management Committee will continue to monitor target behaviors, gradual dose reductions, and psychotropic medication use for all residents at least monthly. These have been reviewed for all residents to ensure appropriate identification of target behaviors Clinical Manager RN-B will monitor documentation of target behaviors weekly until the next Quality Assurance Committee meeting. Results will be reported and a determination will be made by the committee as to the continued need for audits.	

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medications. It recommended to continue to monitor the efficacy of the medications. It stated that R57 was readmitted back to the facility on 8/27/15 with new orders for Risperdal. R57 did not have any suicidal comments this month. It recommended to continue to same plan of care.

R57's medication administration record (MAR), reviewed from 6/1/13 through 6/30/16, indicated that the resident had been taking the Ativan and Risperdal as prescribed.

R57's care plan, dated 10/3/2014, stated that the resident had a potential for altered mood related to diagnoses of anxiety, depression, panic and dependent personality disorder. R57 had a lengthy psychological history with prior hospital stays in a behavioral healthcare unit and had a history of electroconvulsive treatment along with suicidal ideation. R57 was followed by mental health which R57 reported as beneficial. R57 had a history of tongue thrusting and sucking and thrusting the lower lip. The care plan encouraged the staff to monitor R57 for changes and declines in her mood and address them as needed. The care plan also recommended to monitor her psychological medication as directed by the facility policy. It advised to question R57 about hallucinations, delusions, wanting to die and if she had a plan to commit suicide.

R57's doctor's progress note, dated 6/6/2016, stated that the resident remained fragile psychiatrically which contributed to difficult psychopharmatherapuetic management. It stated that something must be done about R57's polypharmacy.

When interviewed on 6/29/2016 at 1:19 p.m., R57

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was asked which types of behaviors she exhibited when she became anxious. She stated that when she was anxious she tended to isolate herself from human company.

When interviewed on 6/29/16 at 1:32 p.m. nursing assistant (NA)-F was asked what target behaviors and mood symptoms she had been instructed to notify the nurses in order to document. NA-F stated that R57 would get very angry if someone were to call her a man. NA-F stated that R57 did not get along with a previous roommate and would say things but that had been resolved. When asked if R57 did tend to isolate herself, NA-F stated that R57 did have a tendency to isolate herself a lot. NA-F stated that she saw R57 isolate herself once or twice a week. When asked if R57 had any hallucinations, NA-F stated no but stated a couple months ago when R57 had gone to the hospital she was seeing things and talking to herself.

When interviewed on 6/30/16 at 10:18 a.m., NA-G was asked what target behaviors she had been instructed to notify the nursing staff in order to document. NA-G stated that R57 did not have any behaviors that she knew of to report. NA-G stated that she did not report any behaviors as R57 did not exhibit any. When asked if R57 tended to isolate herself, NA-G denied that R57 isolated herself. When asked if R57 had any hallucinations or delusions, NA-G denied that as well.

When interviewed on 6/30/16 at 10:28 a.m., NA-H stated that she had never seen R57 exhibit any behaviors such as isolation or hallucinations or delusions. NA-H stated that she had never heard that R57 was suicidal or had expressed

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F 329	Continued From page 27 thoughts of killing herself. NA-H stated that R57 seemed calm and did not tend to isolate herself. When interviewed on 6/30/16 at 10:35 a.m., registered nurse (RN)-B stated that R57's psychiatrist had prescribed both the Ativan and the Risperdal. R57's primary care physician did not prescribe these medications. RN-B was asked what specific target behaviors the nursing staff had been monitoring for to determine if the two medications were affective or not. RN-B stated R57 had been monitored for making suicidal comments. RN-B stated that R57 had started on Risperdal back in August 2015 when she had been in the hospital. RN-B stated that the Ativan had not been something that R57 was just prescribed. RN-B stated that R57 had been on the medication prior to coming to the facility. When asked what resident centered behaviors of anxiety R57 had exhibited RN-B stated that R57 would make frequent repetitive health complaints which was due to her anxiety. When interviewed on 6/30/16 at 12:30 p.m., RN- stated that R57 had never exhibited psychotic features. She stated when R57 had been placed on Risperdal and came back to the facility, the interdisciplinary team (IDT) had reviewed her behaviors. She stated at the time the only thing that R57 had exhibited was that one time R57 had made a suicidal comment and so the nursing staff had started monitoring for that. When interviewed on 6/30/16 at 2:32 p.m., the director of nursing (DON) was informed of the lack of mood and behavior monitoring. The DON said that they should have been identified and monitored.	F 329		

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F 329	Continued From page 28 Review of the Psychotropic Medication Policy and Procedure, last reviewed on 2/6/2014, it stated that each resident's drug regimen must be free from unnecessary medications. It identified unnecessary drugs as any medication used without adequate monitoring. When antipsychotic medication was initiated, it stated that the resident was monitored to determine the effectiveness of the medication. Behaviors were to be documented on the behavior documenting sheet.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the	F 334		7/21/16

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F 334	Continued From page 29 influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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F 334	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 residents (R43, R12, R38, R4 and R35) was offered and/or received the 13-valent pneumococcal conjugate vaccine (PCV13) vaccination as recommended by Centers for Disease Control (CDC). Findings include: R43's Admission Record, dated 1/6/2015, indicated that the resident had a diagnosis of Alzheimer's disease. R43's Immunization Report, dated historically (11/27/2001), indicated that the resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) but not the PCV13. R12's Admission Record, dated 5/3/2010, indicated that the resident had diagnoses of Alzheimer's disease and chronic obstructive pulmonary disease (COPD). R12's Immunization Report, dated 5/7/2011, indicated that the resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) but not the PCV13. R38's Admission Record, dated 3/2/2012, indicated that the resident had a diagnosis of mild cognitive impairment. R38's Immunization Report, dated historically (12/1/2009), indicated that the resident had received the 23-valent pneumococcal	F 334	As noted, all identified residents had received the 23-valent pneumococcal polysaccharide vaccine and there had been initial discussion of the need to offer the PCV13 vaccine. R43, R12, R38, R4, and R35 (or responsible parties) have now received information about the 13-valent pneumococcal conjugate vaccine and have completed a written form indicating their preference in regard to receiving the PCV13 vaccine. If their preference is to receive PCV13, that information will be passed on to their primary physician, who will be responsible for determining the timing of the vaccination according to CDC recommendations and for giving the order for the vaccination. The immunization records of all residents will be reviewed in conjunction with their next scheduled physician visit. Information about PCV13, if the resident has not yet received it, will be given to responsible parties by the Rounds Nurse when she gives notification to them of the date of the next scheduled physician visit. The form indicating acceptance or declination of PCV13 must be completed before the physician can address it. The Director of Nursing will compile a list of existing residents who have not received the PCV13 vaccine and give the information to the Rounds Nurse for further action as described above. New	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	06/30/2016

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
F 334	Continued From page 31 polysaccharide vaccine (PPSV23) but not the PCV13. R4's Admission Record, dated 10/26/2015, indicated that the resident had diagnoses of dementia and cardiomyophathy. R4's Immunization Report, dated historically (4/1/2002), indicated that the resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23). R4 received a second PPSV23 on 12/15/2009 but not the PCV13. R35's Admission Record, dated 11/11/2014, indicated that the resident had diagnoses of: diabetes, heart failure and chronic kidney disease. R35's Immunization Report, dated historically (11/1/2011), indicated that the resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) but not the PCV13. When interviewed on 6/30/16 at 2:37 p.m., the director of nursing stated that she started hearing about the new requirements to offer the PCV13 vaccine to residents last year. She stated that she had not yet begun to push the policy yet but the Medical Director had begun talking about it. She stated that they haven't begun instituting offering it yet but it was going to be in the works.	F 334	residents will receive this information at admission. The DON or Infection Control list will report the number of residents as well as how many are accepting or declining PCV13 at, at least, the next two quarterly Infection Control/Safety meetings. The need for continued reporting will be determined at the second meeting.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		7/21/16

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	245447	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 32 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to track and trend ongoing infections to	F 441	Facility would like to note that cellulitis is a non-contagious condition and posed no	

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F 441	Continued From page 33 determine if staff education was necessary to prevent infections. This included review of R35 who had an infection recorded on the April 2016 infection log. This had the potential to effect all residents, staff and visitors. Findings include: R35 was included on the April 2016 infection log with diagnosis of Cellulitis. Documentation included antibiotic of Bactrim DS give one for ten days. Start date 4/5/16 and end date 4/15/2016. no other information found on log. No indication if antibiotic was affective and if cellulitis had cleared. There was no indication if education of staff was given due to lack of trending. Review of the facility's Monthly Infection Report for All Nursing Units for April, May and June 2016 contained a total amount of infections for each month. Infections were color coded on a map of the facility which identified which wing each infection was located. An order listing report for all three months only indicated residents who had received antibiotics, indication for use of antibiotics, and start and stop dates of the antibiotics. The infection control logs lacked all residents who had an infection that was not treated with an antibiotic, an overall assessment of infection trends and lacked identification of facility acquired infections. In addition, the logs did not reflect documentation of preventative measures to stop or reduce the risk for spread of infections that had occurred in the facility during April, May and June 2016. When interviewed on 6/30/2016 at 2:08 p.m., the infection control nurse, (LPN)-A stated that residents were monitored when they were placed	F 441	potential threat to other residents, staff, or visitors. Facility uses colored coded map of facility to assist in tracking infections and identifying if clusters of infections exist. Supervisory staff are given morning report daily including information related to number, types and locations of infections present in the facility, whether or not the resident is receiving an antibiotic. Based on this information a determination may be made to increase hand washing audits, to provide additional education to staff, or to contact Medical Director regarding possible need for quarantine. Nurses complete infection notes in the progress notes when a resident is receiving an antibiotic. The facility has multiple policies in place related to infection control, such as hand-washing, universal precautions, procedures for cleaning and disinfecting equipment, etc. The Infection Control nurse also does observations of nursing assistants performing cares to monitor infection control procedures. In addition to continuing these practices, the DON will maintain an infection log, tracking all infections and documenting the assessment of trends or the need for preventative measures. The Administrator will review the log before the next quarterly Infection Control meeting and will discuss with the DON what changes, if any, might be made.	

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F 441	Continued From page 34 on antibiotics. She stated that the infection should have resolved when they were given the last dose of medication. She stated that the staff should be writing in an infection note whether the infection was resolved or not. A copy was requested of the facility's policy regarding tracking and trending infections.	F 441	The DON will report on the progress and any problems or challenges with the log at the next Infection Control meeting and the next quarterly Quality Assurance meeting.	
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520		7/19/16

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F 520	Continued From page 35 by: Based on interview and document review, the facility failed to ensure the medical director, or designated physician, attended quality assessment and assurance (QAA) meetings for 3 of 4 quarterly QAA meetings. Findings include: Review of the facility's QAA meeting attendance records, reviewed from 7/13/15 to 4/11/16, revealed the medical director attended the QAA meeting held on 7/13/15 and not again until 4/11/16 (a period of nine months). The attendance records revealed no physician attended the QAA meetings held on 9/28/15, 11/9/15 and 1/18/16. On 6/30/16, at 2:07 p.m., quality assurance coordinator (QAC)-B confirmed the medical director had not attended the QAA meetings as required quarterly. The QAC-B stated the facility tried to coordinate the meetings for when the medical director was in the facility for rounds so he can be present. The QAC-B stated no other physician was present in place of the medical director. The QAC-B stated she was aware the Medical Director was not attending the meetings. The facility policy, undated, indicated the following individuals will serve on the committee: Medical Director. The committee will meet at least quarterly.	F 520	It has proven difficult at times for the Medical Director to attend all QA meetings since his time to see residents and accomplish other tasks is limited. However, he reads the Minutes from any meeting he was not able to attend and is easily contacted for input about any quality issues. After the survey, the QA Coordinator contacted the Medical Director to develop a plan to improve his attendance at QA meetings. This involves more communication regarding his scheduled time in Austin and the possibility of his attending through Skype if necessary.	

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	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2016**

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SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST AUSTIN, MN 55912**

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K 000	INITIAL COMMENTS 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. 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	K 000	EPOC	

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

Electronically Signed | 07/21/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 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. 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. The facility has a capacity of 59 beds and had a census of 57 at the time of the survey.	K 000		

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K 000	Continued From page 2	K 000		
K 018 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the	K 018	The noted basement door has been planed to ensure positional latching capability.	7/6/16

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	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2016**

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SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST** **AUSTIN, MN 55912**

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K 018	Continued From page 3 door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 Findings include: On facility tour between 11:00am and 2:00pm on 06/29/2016, observation revealed, that the the following was found: 1.Basement hallway door does not latch positional when tested. These deficient practices were confirmed by the Facility Maintenance at the time of discovery.	K 018		

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 _____	**06/29/2016**

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SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST AUSTIN, MN 55912**

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K 000	INITIAL COMMENTS A Life Safety Code Initial 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 57 at the time of the survey.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/21/2016

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.

Electronically submitted

July 11, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5447026 and Complaint Number H5447008

Dear Ms. Mathews-Halverson:

The above facility was surveyed on June 27, 2016 through June 30, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5447008 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00393	A. BUILDING: _____ B. WING _____	06/30/2016

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00393	A. BUILDING: _____ B. WING _____	06/30/2016

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 27, 28, 29 and 30, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, a complaint investigation were also completed at the time of the licensing survey. An investigation of complaint H5447008 was completed and was not substantiated.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident	2 255		7/21/16

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2 255	Continued From page 2 reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical director, or designated physician, attended quality assessment and assurance (QAA) meetings for 3 of 4 quarterly QAA meetings. Findings include: Review of the facility's QAA meeting attendance records, reviewed from 7/13/15 to 4/11/16, revealed the medical director attended the QAA meeting held on 7/13/15 and not again until 4/11/16 (a period of nine months). The attendance records revealed no physician attended the QAA meetings held on 9/28/15, 11/9/15 and 1/18/16. On 6/30/16, at 2:07 p.m., quality assurance coordinator (QAC)-B confirmed the medical director had not attended the QAA meetings as required quarterly. The QAC-B stated the facility tried to coordinate the meetings for when the medical director was in the facility for rounds so he can be present. The QAC-B stated no other physician was present in place of the medical director. The QAC-B stated she was aware the Medical Director was not attending the meetings. The facility policy, undated, indicated the following individuals will serve on the committee: Medical Director. The committee will meet at least quarterly. SUGGESTED METHOD OF CORRECTION: The administrator could educate the physician or	2 255	Corrected	

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2 255	Continued From page 3 his/her representative on the importance of participating in QA activities. Monitoring for compliance needs to be included too. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status;	2 540		7/21/16

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2 540	Continued From page 4 M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facilty failed to comprehensively assess missing/broken teeth for 1 of 3 residents (R7) reviewed for dental. Findings include: R7's Admission Record indicated an admission date of 3/26/15. Admission Care & Assessment Plan dated 3/26/15 oral status revealed "some missing teeth." Admission Minimum Data Set (MDS) dated 4/2/15 indicated no dental concerns. Annual MDS dated 3/10/16 indicated no dental concerns. On 6/30/16 at 10:04 a.m. R7 stated he had three or four broken and missing teeth. R7 denied any problems chewing and stated he was independent with his dental cares. On 6/30/16 at 12:57 p.m. registered nurse (RN)-A, a nurse manager, was interviewed regarding R7's MDS dental assessments. "That was an error on my part. I will add it to his care plan. Every quarter in the care conference we address if he has any concerns. He did not have any concerns or want to see the dentist." Facility Assessment and Care Plan System Policy dated 1/5/16 reads, "It is the policy of Sacred Heart Care Center to provide a comprehensive interdisciplinary assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental, and psychosocial	2 540	Corrected	

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2 540	Continued From page 5 functioning possible. This comprehensive assessment in turn is used to develop and individualize a comprehensive plan of care." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to ensuring assessments are comprehensive. The DON or designee, could provide training for all nursing staff . The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to care plan missing teeth for 1 of 3 residents (R51) reviewed for dental status. Findings include:	2 560	Corrected.	7/21/16

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2 560	Continued From page 6 On 6/27/16, at 3:18 p.m., observation revealed R51 had two missing teeth on the left side of his mouth (one on the top gum line and one on the bottom gum line). R51's facility Admission Assessment, dated 2/3/14, identified oral status, some missing teeth. R51's Nursing Assessment dated 4/27/16, oral/dental status failed to identify missing teeth. R51's care plan, print date 6/29/16, identified self-care deficit dressing, bathing, grooming related to weakness, impaired sitting, standing balance, ability varies day to day, needs supervision and verbal cues. Diagnoses of anxiety, cognitive impairment, anemia, neuropathy, cataract, macular degeneration and legal blindness. Resident and family prefer only as needed dental appointments. Facilitate dental appointments as resident/family request. Resident brushes own teeth after set up. On 6/28/16, at 2:56 p.m., registered nurse (RN)-A stated she was responsible for completing the oral assessments and does visually look in the resident's mouth at the time the assessment is completed. RN-A stated she was not aware R51 had missing teeth. RN-A reviewed R51's facility Admission Assessment, dated 2/3/14, and confirmed the assessment identified R51 had some missing teeth and R51's Nursing Assessment dated 4/27/16, oral/dental status failed to identify missing teeth. At 3:16 p.m., RN-A observed R51's teeth and confirmed, on the left side of R51's mouth, R51 had one missing tooth on the top gum line and bottom gum line. RN-A confirmed R51's care plan failed to include missing teeth.	2 560		

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2 560	Continued From page 7 On 6/29/16, at 1:15 p.m., the director of nursing stated if missing teeth was identified on the assessment and if an issue with the resident then missing teeth should be on the care plan. The facility Assessment and Care Plan System-Care Plan and Conference-Interdisciplinary, dated 1/5/16, indicated Procedure 5. The care plan team is to assure that the following areas are addressed and/or care planned. Completed by the facilitator. e. Overall physical status. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all employees responsible for developing the comprehensive care plan to include all areas of cares and services identified on the comprehensive assessment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete facial hair grooming as care planned for 1 of 1 resident (R5) observed for activities of daily living.	2 565	Corrected.	7/21/16

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2 565	Continued From page 8 Findings include: R5 had been observed on 6/27/16, at 3:27 p.m. and 6/28/16, at 8:42 a.m. R5 had long thin black/grey facial hair on her chin and upper lip. R5's quarterly Minimum Data Set (MDS) dated 3/30/16 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4 and extensive physical assist from two staff members for personal hygiene. R5's care plan included R5 had a self-care deficit in areas of dressing, bathing, and grooming related to mild cognitive impairment. The care plan directed, "staff shave resident." During an interview on 6/28/16, at 1:26 p.m. nursing assistant (NA)-C reported R5's shower days were Thursday evenings, and indicated R5 could wash her face, and arms. NA-C stated "We take care of nails and facial hair." NA-C stated residents should be checked for facial hair every day. NA-C stated it looked like R5 had not been shaved in a while and needed to be done. NA-C explained the facility has attempted for family to bring in a razor. NA-C reported she thought the facility had a community razor. During an interview on 6/28/16, at 1:32 p.m. licensed practical nurse (LPN)-B indicated if residents do not have their own razors we contact family to bring one in for them. LPN-B reported the facility had a community razor that was available if the resident did not have one. LPN-B reported multiple attempts had been made for family to bring in working razors. During an interview on 6/29/16, at 12:45 p.m.	2 565		

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2 565	Continued From page 9 director of nursing (DON) stated, the facility does not have a community razor for infection control purposes and we request family members provide the razors. DON explained if the family did not bring one in then facility would check the resident account. DON explained shaving preferences should be included in the care plan, staff should follow the care plan, and if the resident was not shaved the reason should be documented in the record. Facility policy Activities of Daily Living (Daily Life Functions) last reviewed on 1/5/16 included, "The purpose of activities of daily living is to provide assistance to resident for daily life functions. To supervise resident activities in order to maintain optimum functions as long as possible, and to re-educate in techniques of daily life function. The policy did not include requirements for ensuring shaving preferences or procedures." Facility policies AM (Morning) Care, HS (bedtime) Cares, and Hair Care did not include requirements for ensuring shaving preferences or procedures. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review hygiene policies with direct care staff members and provide education as needed. The DON or designee could then develop and implement an auditing system as part of their quality assurance to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 570	Continued From page 10	2 570		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan to include anxiety symptoms treated with medication and ongoing monitoring and target anxiety behaviors, goals with individualized interventions for 1 of 5 residents (R5) reviewed for unnecessary medications. Findings included: R5's facility admission record included diagnosis of anxiety disorder. R5's quarterly Minimum Data Set (MDS) dated 3/20/16 included diagnoses of anxiety disorder and demonstrated fluctuating behaviors of inattention, severe cognitive impairment with a Brief Interview for Mental Status score of four. The MDS reported R5 was administered anti-anti-anxiety medications every day during the look-back period. R5's current printed physician's orders provided by the facility on 6/30/16 included Alprazolam 0.25 milligram (mg) by mouth as needed (PRN)	2 570	Corrected.	7/21/16

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2 570	Continued From page 11 for anxiety up to daily for anxiety or dyspnea (shortness of breath); the order reflected a start date of 3/23/16. The orders further reflected the PRN order for Alprazolam was increased to give 0.25 mg every night for anxiety or dyspnea on 5/11/16. Physician's order also included Buspirone 15 mg twice a day for anxiety with a start date of 3/31/16. R5's Medication Administration Record for May and June 2016 reflected nightly administration of Alprazolam 0.25 mg (nightly after 5/11/16)and twice-daily administration of Buspirone 15 mg. R5's current care plan provided by the facility on 6/30/16 did not identify diagnosis of anxiety and lacked a plan of care for anxiety target behavior monitoring and interventions for symptom management. The care plan also lacked identification of monitoring and management of prescribed anti-anxiety medications. During observations on 6/27/16, at 3:27 p.m. R5 was resting in her bed with her eyes closed. During an observations on 6/28/16 at 8:42 a.m. and at 1:26 p.m. R5 was sitting quietly in her wheelchair. During an interview on 6/28/16, at 2:20 p.m. director of nursing (DON) reviewed R5's care plan and indicated there was not a plan of care for anxiety and stated there should be one. DON stated R5's care plan would be updated today. Facility policy Medication Management Policy last reviewed 2/7/16 included, "Information gathered during the initial and ongoing evaluations are incorporated into a comprehensive care plan that reflects appropriate medication-related goals and parameters for monitoring the resident's condition and ongoing need for medication(s), including, but not limited to, what is monitored, who will be responsible fro monitoring, and how often and when a re-evaluation is necessary." Facility policy Psychotropic Medication Policy and	2 570		

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2 570	Continued From page 12 Procedure included, "Medications use is not the sole approach for behavioral intervention. Other interventions will be identified in the care plan." SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures and the Resident Assessment Instrument (RAI) manual, make changes to existing policies and procedures as necessary. The facility could then provide education to staff members who develop and implement the care plan. The facility could then develop and implement an auditing system for the care plan to ensure all resident assessed areas that require a plan of care are addressed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide hygiene assistants for a dependent resident according to the care plan for 1 of 1 resident (R5) reviewed for activities of daily living. Findings included: R5 had been observed on 6/27/16, at 3:27 p.m.	2 920	Corrected.	7/21/16

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2 920	Continued From page 13 and 6/28/16, at 8:42 a.m. R5 had long thin black/grey facial hair on her chin and upper lip. R5's quarterly Minimum Data Set (MDS) dated 3/30/16 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4 and extensive physical assist from two staff members for personal hygiene. R5's care plan included R5 had a self-care deficit in areas of dressing, bathing, and grooming related to mild cognitive impairment. The care plan directed, "staff shave resident." During an interview on 6/28/16, at 1:26 p.m. nursing assistant (NA)-C reported R5's shower days were Thursday evenings, and indicated R5 could wash her face, arms and underneath her breasts. NA-C stated "we take care of nails and facial hair." NA-C stated residents should be checked for facial hair every day. NA-C stated it looked like R5 had not been shaved in a while and needed to be done. NA-C explained the facility has attempted for family to bring in a razor. NA-C reported she thought the facility had a community razor. During an interview on 6/29/16, at 12:45 p.m. director of nursing (DON) stated, the facility does not have a community razor for infection control purposes and we request family members provide the razors. DON explained if the family did not bring one in then facility would check the resident account. DON explained shaving preferences should be included in the care plan, staff should follow the care plan, and if the resident was not shaved the reason should be documented in the record. Facility policy Activities of Daily Living (Daily Life	2 920		

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SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

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2 920	Continued From page 14 Functions) last reviewed on 1/5/16 included, "The purpose of activities of daily living is to provide assistance to resident for daily life functions. To supervise resident activities in order to maintain optimum functions as long as possible, and to re-educate in techniques of daily life function. The policy did not include requirements for ensuring shaving preferences or procedures." Facility policies AM (Morning) Care, HS (bedtime) Cares, and Hair Care did not include requirements for ensuring shaving preferences or procedures. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review hygiene policies with direct care staff members and provide education as needed. The DON or designee could then develop and implement an auditing system as part of their quality assurance to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21380	MN Rule 4658.0800 Subp. 2 Infection Control; Direction of Program Subp. 2. Direction of program. A nursing home must assign one person, either a registered nurse or a physician, the responsibility of directing infection control activities in the nursing home. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to appoint a registered nurse or physician to	21380	Corrected	7/21/16

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21380	Continued From page 15 oversee the facility wide infection program. This had the potential to effect all residents, staff and visitors. Findings include: R35 was included on the April 2016 infection log with diagnosis of Cellulitis. Documentation included antibiotic of Bactrim DS give one for ten days. Start date 4/5/16 and end date 4/15/2016. no other information found on log. No indication if antibiotic was affective and if cellulitis had cleared. There was no indication if education of staff was given due to lack of trending. Review of the facility's Monthly Infection Report for All Nursing Units for April, May and June 2016 contained a total amount of infections for each month. Infections were color coded on a map of the facility which identified which wing each infection was located. An order listing report for all three months only indicated residents who had received antibiotics, indication for use of antibiotics, and start and stop dates of the antibiotics. The infection control logs lacked all residents who had an infection that was not treated with an antibiotic, an overall assessment of infection trends and lacked identification of facility acquired infections. In addition, the logs did not reflect documentation of preventative measures to stop or reduce the risk for spread of infections that had occurred in the facility during April, May and June 2016. When interviewed on 6/30/2016 at 2:08 p.m., the infection control nurse, (LPN)-A stated that residents were monitored when they were placed on antibiotics. She stated that the infection should have resolved when they were given the last dose of medication. She stated that the staff should be	21380		

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21380	Continued From page 16 writing in an infection note whether the infection was resolved or not. A copy was requested of the facility's policy regarding tracking and trending infections. SUGGESTED METHOD OF CORRECTION: The director of nursing should assign a registered nurse to have oversight of the entire facility infection program and frequently monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21380		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		7/21/16

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21426	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 employees (nursing assistant - NA-I, NA-J, NA-K, registered nurse - RN-C, and dietary aide - DA-A) received a tuberculin skin testing (TST) according to the Centers for Disease Control and Prevention (CDC) guidelines; failed to insure a current written Tuberculosis (TB) risk assessment; failed to ensure the facility had written TB infection control procedures as required. This had the potential to affect all residents, staff and visitors. Findings include: LACK OF TWO STEP TST ACCORDING TO THE CDC GUIDELINES FOR STAFF: NA-I was hired on 2/22/16, and had a first step TST on 2/24/16, and a second step TST on 3/8/16, with readings of 0 mm (millimeters) and negative on 2/26/16 and 3/10/16. The documented information failed to include the time of day the first and second TST's were administered and the time of day the first and second TST's were read. NA-J was hired on 12/14/15, and had a first step TST on 12/16/15 at 10:30 a.m., with readings of 0 mm and negative on 12/16/15. The documented information on 12/16/15, failed to include the time of day the first TST was read. NA-K was hired on 10/5/15, and had a second step TST on 3/7/16, with readings of 0 mm on 3/10/16. The documented information failed to include the time of day the second TST was	21426	Corrected	

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administered and the time the time of day the second TST was read and lacked the reading of negative. In addition, NA-K's record identified a TB screen was completed on 3/7/16 (5 months after hire).

RN-C was hired on 3/15/26, and had a first TST on 3/22/16, with readings of 0 mm on 3/24/16. The documented information failed to include the reading of negative. In addition, RN-C's record identified a TB screen was completed on 3/22/16 (7 days after hire) and the first TST was not given 90 days of hire as required.

DA-A was hired on 10/16/15, and had a first TST on 10/27/16, with reading of 0 mm on 10/24/16, but failed to include the reading of negative. The second TST on 2/12/16, which failed to include read results of the day, the time and documented results of 0 mm or negative. The third TST on 3/3/16, which failed to include the time the TST was administered. In addition, DA-A's record identified a TB screen was completed on 10/22/16 (6 days after hire) and the first TST was not within 90 days of hire as required.

On 6/30/16, at 1:06 p.m., licensed practical nurse (LPN)-A stated she did not know the reading of positive or negative had to be recorded in addition to 0 mm. LPN-A verified the information as above for staff was lacking.

The facility policy Tuberculin (Mantoux) Interpretation Results, dated 6/1/12, indicated a licensed nurse must read the results of the TB test within 48-72 hours after the test is administered. Record time as well as date that the results are read.
The policy Tuberculin (Mantoux) Testing Newly

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21426	Continued From page 19 Hired Employees and Volunteers, dated 9/8/15, indicated licensed nurse will complete the baseline TB screening tool for newly hired employees/volunteers. However, the policy failed to address an employee may begin working with patients after a negative TB symptom scree and a negative TST dated within 90 days before hire. TB RISK ASSESSMENT On 6/30/16, the director of nursing (DON) provided a facility TB risk assessment dated 4/17/12, and confirmed the risk assessment was the most recent completed assessment the facility had. The DON stated LPN-A was in the process of completing a current facility risk assessment, but had not yet completed the risk assessment due to the county did not have numbers to complete the required information. On 6/30/16, at 1:06 p.m. LPN-A confirmed the last TB risk assessment completed was dated 4/17/12. The facility policy TB Exposure Control Plan, dated 9/8/15, indicated Risk Assessment: the risk will be assessed annually in March of each year. TB INFECTION CONTROL PLAN LACKED THE FOLLOWING: Review of the facility policy TB Exposure Control Plan, dated 9/8/15, and the facility policy TB resident assessment and transfer/Discharge, dated 4/15/09, included early recognition and referral procedures for TB as required. However, the policies failed to include written TB infection control procedures for isolation for residents with active TB and failed to include information about working with the local or state public health department to conduct a TB contact investigation if health care-associated transmission of M. tuberculosis is suspected.	21426		

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21426	Continued From page 20 On 6/30/16, at 1:06 p.m., LPN-A confirmed the current policies lacked information in regards to above. SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21490	MN Rule 4658.1005 Subp. 4 Social Services; Updating Assessment Subp. 4. Updating the assessment. The psychosocial assessment must be reviewed at least annually and updated as necessary. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess mood changes after a substantial increase in depressive symptoms for 1 of 5 residents (R58) reviewed for unnecessary medications. Findings included: R58 had been observed on 6/27/16, at 3:07 p.m., 6/28/16, at 9:03 a.m., and 6/29/16 at 11:00 a.m. R58 was lying in bed awake. During an interview on 6/29/16, at 8:58 a.m. while R58 was lying in bed awake. In response to the question, "I noticed you stay in your room, is there a reason you like to be alone?" R58 stated, "I don't know where to go or what to do and when I talk to people they look at me like I'm a stupid idiot." R58 stated sometimes she feels sad. R58	21490	Corrected	7/21/16

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21490	Continued From page 21 was then asked, "How do staff help you with your depression?" R58 responded, "I suppose they talk to me about it, but I don't know how often." After several more minutes of conversation, R58's sentence structure was not comprehendible for meaning. R58 had diagnoses of dementia with behavioral disturbance, major depressive disorder, restlessness and agitation, anxiety disorder, and abnormal weight loss according to the facility admission record. R58's last Care Area Assessment performed on 12/29/15 included, "PHQ-9 [a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression] score of (04) remains low. She consistently admits to feeling tired (almost all the time) and having occasional down/sad days but denied difficulty with any of the remaining items. Current medication therapy for her depression remains beneficial [Celexa, Mirtazapine, Divalproex for migraines but also used to control mood, and Quetiapine]. No additional issues or concerns with this review. Will continue to monitor for potential changes in cognition and mood and address PRN [as needed]." R58's quarterly Minimum Data Set (MDS) dated 3/23/16 did not identify diagnosis of depression and anxiety, indicated severe cognitive impairment with a Brief interview for Mental Status (BIMS) score of four without symptoms of delirium or behaviors. The MDS included a PHQ-9 score of 3 and identified R58 had not reported feelings of being better off dead, however felt tired and had little energy nearly every day. The MDS identified use of antipsychotic and anti-depressant medications. R58's quarterly MDS dated 6/22/16 included and identified diagnosis of depression and dementia with behavioral disturbance, use of antipsychotic	21490		

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and anti-depressant medications. The MDS also identified severe cognitive impairment with a BIMS score of zero. The assessment now reflected fluctuating delirium signs and symptoms of inattention and disorganized thinking as well as physical behavioral symptoms directed towards others 1 to 3 days during the assessment period. The PHQ-9 reflected a substantial increase in depressive symptoms with a score of fifteen indicating major depression or moderately severe. The PHQ-9 reported R58 now had thoughts of being better off dead half or more of the days during the look back period, had little interest or pleasure in doing things nearly every day, feeling tired nearly every day, and feeling down, depressed, and hopeless half or more of the days.
R58's physician order dated 4/11/16 included decrease Mirtazapine (anti-depressant medication) to 15 mg every bedtime.
R58's behavioral progress notes reviewed from 4/1/16-6/27/16. Progress notes reported delusional behavior patterns such as resident reporting someone in her room and they were going to kill her and reports of other people being in her room. Behavioral progress note dated 5/11/16 reflected a steady increase in target behavior of "accusing staff of lying to her" from January through April 2016.
R58's physician visit progress note dated 5/17/16 included, "Nursing staff indicates no new problems. Her husband recently died, which she does not remember." Physician note identified depression likely to be mild. Physician progress note indicated R58 had weight loss likely related to dementia however, physician indicated the Divalproex (mood altering medication) was decreased from 125 milligrams (mg) three times a day to 125 mg twice per day related to weight loss as a possible adverse drug reaction.

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21490	Continued From page 23 R58's social services note dated 6/22/16, at 11:35 a.m. included, "RE [regarding] mood: Today's PHQ-9 score of (15) does show a significant decline in mood, simply for the fact that she was so vocal during our visit with how she feels. [R58] was able to stay on task and respond to every one of the items re mood, and with quite detailed responses. She readily admitted to little/no interest in doing things (d/t [due to] poor eyesight/hearing per her comment), frequently frustrated & depressed, occasional insomnia, tired on a daily basis, feeling bad about herself, difficulty concentrating, and thoughts re better off dead. "They can just throw a sheet over me and wait for me to die" was her exact response. She denied any potential for self-harm when asked, and went on to state "that just isn't me." "[R58] has likely had these feelings over the past several months, but per recent resident interviews, she has consistently denied them when specifically asked. [R58] continues to spend a good majority of her time resting in bed. This is per her choice, has been baseline for well over the past year, but not worse or more often this review. Despite sx's [symptoms] present, [R58] can be quite pleasant to visit with, and does well when provided personal attention. No additional issues at this time. Will continue to monitor for potential changes in cognition & mood and address prn [as needed]." R58's record lacked a comprehensive assessment following the substantial increase in depressive mood symptoms and of statements of feeling better off dead in the last quarter even though R58's spouse had died, there had been a decrease in two mood altering medications and increase in delusional and physical behavior patterns. The record further lacked documentation of physician notification. R58's current care plan provided by the facility on	21490		

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21490	Continued From page 24 6/30/16 identified potential for mood alteration related to depression, anxiety, and dementia. The care plan identified the increase of mood score of 15 that indicated moderate depression. The care plan indicated R58 reported little to no interest in things, had sadness/frustration, occasional insomnia, was tired daily, feels bad about self and had made comments of being better off dead without a plan. The care plan identified R58 preferred to be in bed when not visiting with family. R58's care plan identified and included interventions last dated 11/19/14 to manage mood alterations as: · contact medical doctor as needed · facilitate appointment with psych and/or mental services as needed · monitor efficacy and adverse consequences of medications, · monitor for changes/decline in mood and address as needed. · Will evaluate, monitor, intervene or counsel as appropriate/necessary. R58's care plan and record lacked evidence the care plan had been updated after the change in mood score from four to fifteen. During an interview on 6/9/16, at 9:06 a.m. nursing assistant (NA)-D stated we try to get R58 out of bed as often as we can and she stays in bed because she is tired or has pain. NA-D explained to surveyor she was not aware of increase in depressive symptoms or had recently made comments that she felt she would be better off dead, however was aware R58's husband had recently passed away and indicated R58 was not aware of that. NA-D explained R58 since admission liked to be in her room and in bed a lot, however she did not do a lot of wondering. During an interview on 6/29/16, at 9:19 a.m. licensed practical nurse (LPN)-C stated R58 was	21490		

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not one to come out of her room since time of admission. LPN-C stated staff try to get her out of her room as much as possible. LPN-C stated she was not aware R58 had recently expressed feelings she would be better off dead or the increase in depressive symptoms. LPN-C indicated she had not personally seen an increase in depressive symptoms and was not aware if or how social services was involved. LPN-C explained if there was an increase in symptoms then nursing would document in the medical record, notify the physician and family members to see if therapy services were needed.
During an interview on 6/29/16, at 9:25 a.m. activities assistant (AA)-A stated R58 benefited from 1:1 visits in her room and was provided sensory one to one visits. AA-A stated she was not aware of the recent increase in depressive symptoms and R58's feelings of being better off dead.
During an interview on 6/29/16, at 9:30 a.m. with licensed social worker (LSW) stated she had notified the nurse manager of the increase in the PHQ-9 score, and stated, "I don't know that I implemented anything" as a result of the increase in score showing worsening depression. LSW explained the increase in symptoms could have been situational. LSW stated she had written a detailed progress note, updated the care plan to include PHQ-9 score changes, and had implemented the intervention of continue to monitor. LSW reported, "To me interventions are things that you can try they are not solutions, whether they work or not." LSW stated the family had not been updated of the change in mood status and would be updated today (6/29/16) at the scheduled care conference. LSW explained the PHQ-9 score could change from day to day depending on how R58 was feeling at the time of assessment, however LSW stated she had not

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21490	Continued From page 26 made any follow-up visits since the time of the PHQ-9 assessment on 6/22/16. LSW explained residents psychosocial needs are met through social services visits but explained that visits were not based on if the residents received psychotropic medications. In response to the question, "How do you manage mood symptoms?" LSW stated, "We don't manage her mood she has a right to be angry or sad. You just have to take the time to redirect or reassure and find if something is going on." LSW reported, an outside referral for mental health services had not been considered or addressed following the increase in depression symptoms or the statements of being better off dead. During an interview on 6/29/16, at 9:48 a.m. NA-E reported she was not aware of any increase in depressive symptoms or R58's feelings of being better off dead. During an interview on 6/29/16, at 9:51 a.m. LPN-A reported she was not aware of R58's feeling of being better off dead and was not aware of the increase in depressive symptoms. During an interview on 6/29/16, at 12:00 p.m. registered nurse (RN)-A indicated she had not been made aware of the mood status as reported by the social worker. RN-A stated LSW had reported the change this morning (6/29/16) to her. RN-A explained the EHR (electronic health record) system identifies changes on assessments by sending out warning messages of need for further assessment and intervention. RN-A stated a warning message was created as a result of the increase in the PHQ-9 score on 6/22/16, however the social worker had signed the warning, indicating the alert was addressed and follow-up was completed. RN-A stated, if she had been alerted of the mood change score either by the EHR warning or verbal communication she would have completed a	21490		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21490	Continued From page 27 comprehensive mood assessment to determine the possible root cause of the increase in depressive symptoms, notify the physician of the findings as well as direct care staff, and develop and implement immediate interventions. RN-A explained the process is the same regardless if the resident has dementia and/or memory impairments, the mood change needs to be addressed. During an interview on 6/29/16, at 12:23 p.m. director of nursing (DON) stated the changes of the score on the PHQ-9 should have been addressed and reported immediately and interventions put into place. DON stated, it should have been followed up on. A facility policy pertaining providing social services was requested and not received. Facility policy Medication Management Policy, included necessary requirements for assessment and care plan revision based on evaluations performed by nursing staff to justify the use of continued medications. The policy did not address procedures for increases in depressive symptoms. SUGGESTED METHOD OF CORRECTION: The facility could review their social services and nursing services policies and procedures; make changes as needed. The facility could then review/develop and provide education to staff members on depression and mood/behavioral management for residents with dementia. The facility could develop a comprehensive system approach between social services and nursing services to ensure comprehensive assessments, individualized interventions and follow-up are completed by appropriate disciplines when there is an increase in depressive symptoms. The facility could then develop an auditing system as part of their quality assurance to ensure ongoing	21490		

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	00393	A. BUILDING: _____ B. WING _____	06/30/2016

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21490	Continued From page 28 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21490		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify specific target behaviors to determine efficacy for the use of an antianxiety and antipsychotic medications for 1 of	21535	Corrected	7/21/16

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21535	Continued From page 29 5 residents (R57) reviewed for unnecessary medications. Findings include: R57's admission record, dated, 9/25/2014, indicated that the resident had diagnoses of post-traumatic stress disorder, major depressive disorder, mild cognitive impairment, panic disorder, dependent personality disorder and generalized anxiety disorder. R57's physician orders, dated, 8/27/15 indicated that the resident had been prescribed Risperidone (an antipsychotic medication) 2 mg (milligrams) to be taken by mouth at bedtime related to major depressive disorder. In addition, R57 had been prescribed Lorazepam (an antianxiety medication), dated 11/13/15. She was to take 0.5 mg by mouth three times a day related to generalized anxiety. R57's quarterly Minimum Data Set (MDS), dated 2/24/16, indicated that the resident was cognitively intact. R57's psychoactive medication assessment, dated 5/24/16, indicated that the resident was taking 0.5 mg of Ativan three times a day in addition to Risperdal 2 mg every evening. It stated that she suffered from major depression and generalized anxiety. It stated that her behaviors consisted of statements of sadness and anxiety, crying and not sleeping. In summary, it stated that R57 had long term problems with mental illness and use of psychotropic medications. It recommended to continue to monitor the efficacy of the medications. It stated that R57 was readmitted back to the facility on 8/27/15 with new orders for Risperdal. R57 did	21535		

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not have any suicidal comments this month. It recommended to continue to same plan of care.

R57's medication administration record (MAR), reviewed from 6/1/13 through 6/30/16, indicated that the resident had been taking the Ativan and Risperdal as prescribed.

R57's care plan, dated 10/3/2014, stated that the resident had a potential for altered mood related to diagnoses of anxiety, depression, panic and dependent personality disorder. R57 had a lengthy psychological history with prior hospital stays in a behavioral healthcare unit and had a history of electroconvulsive treatment along with suicidal ideation. R57 was followed by mental health which R57 reported as beneficial. R57 had a history of tongue thrusting and sucking and thrusting the lower lip. The care plan encouraged the staff to monitor R57 for changes and declines in her mood and address them as needed. The care plan also recommended to monitor her psychological medication as directed by the facility policy. It advised to question R57 about hallucinations, delusions, wanting to die and if she had a plan to commit suicide.

R57's doctor's progress note, dated 6/6/2016, stated that the resident remained fragile psychiatrically which contributed to difficult psychopharmatherapuetic management. It stated that something must be done about R57's polypharmacy.

When interviewed on 6/29/2016 at 1:19 p.m., R57 was asked which types of behaviors she exhibited when she became anxious. She stated that when she was anxious she tended to isolate herself from human company.

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21535	Continued From page 31 When interviewed on 6/29/16 at 1:32 p.m. nursing assistant (NA)-F was asked what target behaviors and mood symptoms she had been instructed to notify the nurses in order to document. NA-F stated that R57 would get very angry if someone were to call her a man. NA-F stated that R57 did not get along with a previous roommate and would say things but that had been resolved. When asked if R57 did tend to isolate herself, NA-F stated that R57 did have a tendency to isolate herself a lot. NA-F stated that she saw R57 isolate herself once or twice a week. When asked if R57 had any hallucinations, NA-F stated no but stated a couple months ago when R57 had gone to the hospital she was seeing things and talking to herself. When interviewed on 6/30/16 at 10:18 a.m., NA-G was asked what target behaviors she had been instructed to notify the nursing staff in order to document. NA-G stated that R57 did not have any behaviors that she knew of to report. NA-G stated that she did not report any behaviors as R57 did not exhibit any. When asked if R57 tended to isolate herself, NA-G denied that R57 isolated herself. When asked if R57 had any hallucinations or delusions, NA-G denied that as well. When interviewed on 6/30/16 at 10:28 a.m., NA-H stated that she had never seen R57 exhibit any behaviors such as isolation or hallucinations or delusions. NA-H stated that she had never heard that R57 was suicidal or had expressed thoughts of killing herself. NA-H stated that R57 seemed calm and did not tend to isolate herself. When interviewed on 6/30/16 at 10:35 a.m., registered nurse (RN)-B stated that R57's psychiatrist had prescribed both the Ativan and	21535		

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the Risperdal. R57's primary care physician did not prescribe these medications. RN-B was asked what specific target behaviors the nursing staff had been monitoring for to determine if the two medications were affective or not. RN-B stated R57 had been monitored for making suicidal comments. RN-B stated that R57 had started on Risperdal back in August 2015 when she had been in the hospital. RN-B stated that the Ativan had not been something that R57 was just prescribed. RN-B stated that R57 had been on the medication prior to coming to the facility. When asked what resident centered behaviors of anxiety R57 had exhibited RN-B stated that R57 would make frequent repetitive health complaints which was due to her anxiety.

When interviewed on 6/30/16 at 12:30 p.m., RN- stated that R57 had never exhibited psychotic features. She stated when R57 had been placed on Risperdal and came back to the facility, the interdisciplinary team (IDT) had reviewed her behaviors. She stated at the time the only thing that R57 had exhibited was that one time R57 had made a suicidal comment and so the nursing staff had started monitoring for that.

When interviewed on 6/30/16 at 2:32 p.m., the director of nursing (DON) was informed of the lack of mood and behavior monitoring. The DON said that they should have been identified and monitored.

Review of the Psychotropic Medication Policy and Procedure, last reviewed on 2/6/2014, it stated that each resident's drug regimen must be free from unnecessary medications. It identified unnecessary drugs as any medication used without adequate monitoring. When antipsychotic medication was initiated, it stated that the

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21535	Continued From page 33 resident was monitored to determine the effectiveness of the medication. Behaviors were to be documented on the behavior documenting sheet. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures for unnecessary medications and the need for target/mood monitoring to determine effectiveness of each psychoactive medication. Director of nursing could educate staff. Director of nursing could monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		