

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 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.

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• 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

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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).

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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

The REGULATORY OR LSC IDENTIFYING INFORMATION The The Definition The 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. F 000 INITIAL COMMENTS F 000 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance was conducted and compliant investigation ore also completed at the time of the standard survey. The investigation ore compliant the/447008 was completed and found not to be substantiated. F 250 F 250 F 250 F 250 F 250 This REQUIREMENT is not met as evidenced by: and payofosocial well-being of each resident. 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 psychosocial well-being of each resident. 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 psychosocial well-being of each resident. 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 psychosocial well-being of each resident.			AND HUMAN SERVICES		FORM	APPROVED
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Electronically Signed 07/21/201			ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE 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.

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	MB NO. (X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:				PLETED
		245447	B. WING		06/3	80/2016
NAME OF I	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
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F 250	Continued From pa	ige 1	F 250			
	Findings included: R58 had been obse 6/28/16, at 9:03 a.n R58 was lying in be During an interview R58 was lying in be question, "I noticed a reason you like to don't know where to talk to people they lidiot." R58 stated s was then asked, "H depression?" R58 talk to me about it, After several more R58's sentence struc comprehendible for R58 had diagnoses disturbance, major restlessness and ag abnormal weight lo admission record. R58's last Care Are 12/29/15 included, instrument for screa and measuring the of (04) remains low feeling tired (almos occasional down/sa with any of the rem medication therapy beneficial [Celexa, migraines but also Quetiapine]. No add with this review. Wi	erved on 6/27/16, at 3:07 p.m., n., and 6/29/16 at 11:00 a.m. ed awake. on 6/29/16, at 8:58 a.m. while ed awake. In response to the you stay in your room, is there o be alone?" R58 stated, "I o go or what to do and when I look at me like I'm a stupid cometimes she feels sad. R58 low do staff help you with your responded, "I suppose they but I don't know how often." minutes of conversation, ucture was not r meaning. of dementia with behavioral depressive disorder, gitation, anxiety disorder, and ss according to the facility ea Assessment performed on "PHQ-9 [a multipurpose ening, diagnosing, monitoring severity of depression] score to tall the time) and having ad days but denied difficulty aining items. Current for her depression remains Mirtazapine, Divalproex for used to control mood, and ditional issues or concerns II continue to monitor for n cognition and mood and		 Another PHQ-9 was administered on 6/29/16 with a resulting score of RN-A also initiated behavioral chalevery shift for R58. The physician notified on 6/29/16 of the four most scores on the PHQ-9. He express the PHQ-9 is not a valid assessme instrument for nursing home resid with dementia, noting that staff observations are much better india mood. He will see the resident on 7/19/2016 and determine at that ti any treatment changes are warran. The family was notified of the chart the PHQ-9 scores on 6/29/16 as with fact that nursing had not report anything different about R58 is been any change in mood. The behavioral progress note date 5/11/16 stated in its entirety: The the behavior we are monitoring is Adstaff of lying to her. In the month January, the target behavior did not occur. In the month January, the target behavior did not and the month of April it occurred Facility does not agree that the physical of the set of the	of 10. rting on was st recent sed that ents cators of me if nted. nge in vell as ted shaviors. so not ed arget ccusing n of ot occur. ne target th of cur x 1 x 3. rase a s. g anges te the	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED
		245447	B. WING		06/3	30/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
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F 250	3/23/16 did not ider and anxiety, indicat impairment with a E Status (BIMS) scor delirium or behavio PHQ-9 score of 3 a reported feelings of however felt tired a every day. The MD antipsychotic and a R58's quarterly MD identified diagnosis with behavioral dist and anti-depressan identified severe co BIMS score of zero reflected fluctuating of inattention and d physical behavioral others 1 to 3 days of The PHQ-9 reflected depressive sympton indicating major de severe. The PHQ-9 thoughts of being b the days during the interest or pleasure day, feeling tired ne down, depressed, a the days. R58's physician orc decrease Mirtazapi medication) to 15 m R58's behavioral pr 4/1/16-6/27/16. Pro delusional behavior reporting someone going to kill her and	htify diagnosis of depression ed severe cognitive Brief interview for Mental e of four without symptoms of rs. The MDS included a nd identified R58 had not being better off dead, nd had little energy nearly S identified use of nti-depressant medications. S dated 6/22/16 included and of depression and dementia urbance, use of antipsychotic t medications. The MDS also gnitive impairment with a . The assessment now delirium signs and symptoms isorganized thinking as well as symptoms directed towards during the assessment period. ed a substantial increase in ms with a score of fifteen pression or moderately reported R58 now had etter off dead half or more of look back period, had little in doing things nearly every early every day, and feeling and hopeless half or more of ler dated 4/11/16 included ne (anti-depressant	F 2	 50 No other residents were identified having a significant increase in a score without follow-up. If there is an increase in score on PHQ-9 that moves a resident to a level (there are a total of 5 levels) depression, the LSW will notify th Managers and DON of this chang LSW will check with nursing staff any changes in observed behavio document their impressions in a p note. The LSW will talk to a famil member to notify them of the chail PHQ-9 score and to determine if t family has noted any changes in t resident s mood or behaviors. T will make a follow-up visit to the rewithin one week of the increased score and document her observat the resident s mood/behaviors. When notified of an increase in led depression, as measured by the F the CM will review the resident s medications and behavioral chartior designee will notify the physicia will decide if any change in treatm warranted. The LSW and CM will determine if a need for increased visits from S Services or if a referral for psychia services should be considered. The Risk Management Committer continue to review target behavior least monthly during its weekly measured by the resident s monthly during its weekly measured by the resident s mode considered. 	PHQ-9 the different of e Clinical e. The about r and will progress y nge in the he Sident PHQ-9 tions of PHQ-9, tions of PHQ-9, tions of PHQ-9, tions of ent is ocial atric	

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLIT	TIPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245447	B. WING _			30/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWES AUSTIN, MN 55912	ST	
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	behavior of "accusi January through Ap R58's physician vis included, "Nursing s problems. Her husk does not remembe depression likely to note indicated R58 to dementia howev Divalproex (mood a decreased from 12 a day to 125 mg tw loss as a possible a R58's social service a.m. included, "RE PHQ-9 score of (15 decline in mood, sin so vocal during our was able to stay on one of the items re responses. She rea interest in doing thi eyesight/hearing pe frustrated & depress tired on a daily basi difficulty concentrat dead. "They can jus wait for me to die" v denied any potentia and went on to stat has likely had these	steady increase in target ng staff of lying to her" from oril 2016. it progress note dated 5/17/16 staff indicates no new band recently died, which she r." Physician note identified be mild. Physician progress had weight loss likely related er, physician indicated the altering medication) was 5 milligrams (mg) three times ice per day related to weight adverse drug reaction. es note dated 6/22/16, at 11:35 [regarding] mood: Today's 5) does show a significant mply for the fact that she was visit with how she feels. [R58] task and respond to every mood, and with quite detailed adily admitted to little/no ngs (d/t [due to] poor er her comment), frequently sed, occasional insomnia, is, feeling bad about herself, ting, and thoughts re better off st throw a sheet over me and was her exact response. She al for self-harm when asked, e "that just isn't me." "[R58] e feelings over the past several cent resident interviews, she		The DON will review the residents who have been having a change in level measured by the PHQ-9 follow-up was completed She will present the resu at the next two Quality A: Committee meetings. A the need for continued a at that time.	identified as of depression as to determine if as described. Its of her audits ssurance decision as to	
	asked. [R58] contin of her time resting i	nied them when specifically nues to spend a good majority in bed. This is per her choice, for well over the past year, but				

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		AND HUMAN SERVICES				FORM	09/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING			06/;	30/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	personal attention. time. Will continue changes in cognitio needed]." R58's record lacked assessment followid depressive mood sy feeling better off de though R58's spous decrease in two mo increase in delusion patterns. The record documentation of p R58's current care 6/30/16 identified p related to depressio care plan identified 15 that indicated mo plan indicated R58 things, had sadness insomnia, was tired had made comment without a plan. The preferred to be in b family. R58's care plan ide interventions last da mood alterations as contact medica facilitate appoin mental services as monitor efficace of medications, Will evaluate, n as appropriate/nece	es well when provided No additional issues at this to monitor for potential n & mood and address prn [as d a comprehensive ng the substantial increase in ymptoms and of statements of ad in the last quarter even se had died, there had been a bod altering medications and hal and physical behavior rd further lacked hysician notification. plan provided by the facility on otential for mood alteration on, anxiety, and dementia. The the increase of mood score of oderate depression. The care reported little to no interest in s/frustration, occasional daily, feels bad about self and ts of being better off dead care plan identified R58 ed when not visiting with ntified and included ated 11/19/14 to manage s: I doctor as needed thment with psych and/or needed by and adverse consequences anges/decline in mood and monitor, intervene or counsel	F2	250			

Facility ID: 00393

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		AND HUMAN SERVICES				FORM	09/14/2016 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING			06/;	30/2016
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SACREE	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	care plan had been mood score from fo During an interview nursing assistant (N out of bed as often bed because she is explained to survey increase in depress made comments th off dead, however w recently passed aw aware of that. NA-E admission liked to b however she did no During an interview licensed practical n not one to come ou admission. LPN-C s her room as much was not aware R58 feelings she would increase in depress indicated she had r increase in depress aware if or how soo LPN-C explained if symptoms then nur medical record, not members to see if t During an interview activities assistant of from 1:1 visits in he sensory one to one not aware of the rec symptoms and R58 dead. During an interview licensed social work	updated after the change in	F	250			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING			06/3	30/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	implemented anythincrease in score sl LSW explained the have been situation written a detailed pup plan to include PHC implemented the immonitor. LSW report things that you can whether they work of had not been updat status and would be the scheduled care the PHQ-9 score co depending on how assessment, however made any follow-up PHQ-9 assessment residents psychoso social services visit were not based on psychotropic medic question, "How do y symptoms?" LSW se mood she has a rig have to take the tim find if something is outside referral for been considered or increase in depress statements of being During an interviewer reported she was n depressive sympton better off dead. During an interviewer LPN-A reported she	stated, "I don't know that I ing" as a result of the nowing worsening depression. increase in symptoms could al. LSW stated she had rogress note, updated the care Q-9 score changes, and had tervention of continue to rted, "To me interventions are try they are not solutions, or not." LSW stated the family ed of the change in mood e updated today (6/29/16) at conference. LSW explained ould change from day to day R58 was feeling at the time of ver LSW stated she had not visits since the time of the to n 6/22/16. LSW explained cial needs are met through s but explained that visits if the residents received ations. In response to the you manage mood stated, "We don't manage her ht to be angry or sad. You just he to redirect or reassure and going on." LSW reported, an mental health services had not addressed following the sion symptoms or the	F2	250			

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		AND HUMAN SERVICES				FORM	09/14/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING	i		06/;	30/2016
NAME OF	PROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	200 12TH STREET SOUTHWEST		
SACRED	HEART CARE CENT	ER			AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	aware of the increa During an interview registered nurse (R been made aware of by the social worke reported the change RN-A explained the record) system ider assessments by se of need for further a RN-A stated a warn a result of the incre 6/22/16, however th the warning, indicat and follow-up was of had been alerted of either by the EHR v communication she comprehensive mo the possible root ca depressive symptor findings as well as of and implement imm explained the proce the resident has de impairments, the m addressed. During an interview director of nursing (the score on the PH addressed and repo- interventions put int have been followed A facility policy Medic included necessary and care plan revis	se in depressive symptoms. on 6/29/16, at 12:00 p.m. N)-A indicated she had not of the mood status as reported r. RN-A stated LSW had e this morning (6/29/16) to her. EHR (electronic health ntifies changes on nding out warning messages assessment and intervention. ing message was created as ase in the PHQ-9 score on he social worker had signed ting the alert was addressed completed. RN-A stated, if she f the mood change score varning or verbal e would have completed a od assessment to determine ause of the increase in ms, notify the physician of the direct care staff, and develop nediate interventions. RN-A ess is the same regardless if mentia and/or memory ood change needs to be on 6/29/16, at 12:23 p.m. (DON) stated the changes of IQ-9 should have been orted immediately and to place. DON stated, it should		250			

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MELT	PLE CONSTRUCTION		0. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
		245447	B. WING			6/30/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
SACRED	HEART CARE CENT	ſER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 250	Continued From pa continued medicati	age 8 ions. The policy did not is for increases in depressive	F 25	0		
F 272 SS=D	symptoms. 483.20(b)(1) COM ASSESSMENTS		F 27	2		7/21/16
	a comprehensive, reproducible asses functional capacity					
	assessment of a re resident assessme by the State. The least the following:	e a comprehensive esident's needs, using the ent instrument (RAI) specified assessment must include at lemographic information;	C			
	Customary routine Cognitive patterns; Communication; Vision; Mood and behavio					
	Continence;	g and structural problems; and health conditions;				
		l; summary information regarding				
	areas triggered by Data Set (MDS); a	ssment performed on the care the completion of the Minimum nd participation in assessment.				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING		06/3	80/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	Continued From pa	ge 9	F 272	2		
	by: Based on observat review, the facilty fa assess missing/bro (R7) reviewed for de Findings include: R7's Admission Red date of 3/26/15. Adu Plan dated 3/26/15. missing teeth." Adm (MDS) dated 4/2/15 Annual MDS dated concerns. On 6/30/16 at 10:04 or four broken and problems chewing a independent with hi On 6/30/16 at 12:57 (RN)-A, a nurse ma regarding R7's MDS was an error on my plan. Every quarter address if he has al any concerns or wa Facility Assessment dated 1/5/16 reads,	cord indicated an admission mission Care & Assessment oral status revealed "some hission Minimum Data Set indicated no dental concerns. 3/10/16 indicated no dental 4 a.m. R7 stated he had three missing teeth. R7 denied any and stated he was		It is the practice of Sacred Heart C Center to conduct initially and perio a comprehensive, accurate, standar reproducible assessment of each resident's functional capacity and make a comprehensive assessmer resident's NEEDS using the RAI. As stated, R7's Admission Assess noted that R7 had some missing te Also, as stated, on 6/30/16, R7 den any problems chewing and stated h independent with dental care, facts supported the indication of no denta concerns on his MDS. As with all residents, R7 is asked at each care conference if he has any dental cor or would like to schedule a dental appointment. R7 has always respon no to these questions. Clinical Managers, who perform assessments and develop care plat have been informed that missing te must be included even if there is no problem or need associated with th Clinical Managers will make a visual inspection of the mouths of all resid on their wings by 7/21/2016 and rev individual assessments and care pl ensure that missing/broken teeth at	dically rdized to to f a ment eth. ied he was that al encerns inded ms, eeth o em. al dents view ans to	

Facility ID: 00393

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
				IG			
		245447	B. WING _			30/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	AUSTIN, MN 55912 PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 272 F 279 SS=D	condition, in order care that will attain practicable physica functioning possib assessment in turn individualize a con 483.20(d), 483.20(COMPREHENSIV A facility must use to develop, review comprehensive pla The facility must d plan for each resic objectives and tim medical, nursing, a needs that are ide assessment. The care plan must to be furnished to highest practicable psychosocial well- §483.25; and any be required under due to the residem	(k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's an of care. (k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's an of care. evelop a comprehensive care lent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive st describe the services that are attain or maintain the resident's e physical, mental, and being as required under services that would otherwise §483.25 but are not provided t's exercise of rights under the right to refuse treatment	F 27	72 included. CM s will follow for each new admission an comprehensive assessmer DON will audit the assessm plans of three new admissi determine if missing or bro on the nursing admission a also included on the RAI ar She will report audit results QA meeting. A determinati made at that time if addition needed.	d during nts thereafter. nents and care ons to ken teeth noted ssessment are nd care plan. at the October on will be	7/21/16	

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI			0938-039 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					LETED
		245447	B. WING			06/3	0/2016
IAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIC DATE
F 279	Continued From pa	ge 11	F 2	279			
	This REQUIREMEI by:	NT is not met as evidenced					
	Based on observat	tion, interview and record			It is the practice of Sacred Heart Care		
		ailed to care plan missing dents (R51) reviewed for			Center to develop a comprehensive ca plan for each resident that includes	are	
	dental status.				measurable objectives and timetable to		
	Findings include:				meet a resident s medical, nursing, a mental and psychosocial NEEDS that		
	$\Omega = 6/27/16$ at 2:19	p.m., observation revealed			identified in the comprehensive assessment.		
		ng teeth on the left side of his			assessment.		
		top gum line and one on the			R51 has had no problems or needs		
	bottom gum line).				associated with his missing teeth. As		
	DE1's facility Admis	acion Accompany datad			stated in the deficiency, the care plan		
		sion Assessment, dated al status, some missing teeth.			does include his dental preference: Resident and family prefer only as-nee	eded	
		essment dated 4/27/16,			dental appointments.	cucu	
		ailed to identify missing teeth.					
			Ň		Clinical Managers, who perform		
		int date 6/29/16, identified ssing, bathing, grooming			assessments and develop care plans, have been informed that missing teeth		
		s, impaired sitting, standing			must be included even if there is no	'	
		es day to day, needs			problem or need associated with them	۱.	
	supervision and ver	rbal cues. Diagnoses of			Clinical Managers will make a visual		
		npairment, anemia,			inspection of the mouths of all residen		
		ct, macular degeneration and			on their wings by 7/21/2016 and review		
		sident and family prefer only pointments. Facilitate dental			individual assessments and care plans ensure that missing/broken teeth are	SIO	
		sident/family request.			included. CM s will follow this practic	ce	
		own teeth after set up.			for each new admission and during		
					comprehensive assessments thereafter	er.	
	-	p.m., registered nurse (RN)-A			DON will audit the sessentiate and a		
		ponsible for completing the and does visually look in the			DON will audit the assessments and c plans of three new admissions to	are	
		the time the assessment is			determine if missing or broken teeth n	oted	
		tated she was not aware R51			on the nursing admission assessment		
	had missing teeth.	RN-A reviewed R51's facility			also included on the RAI and care plar	n.	
		nent, dated 2/3/14, and ssment identified R51 had			She will report audit results at the Octo QA meeting. A determination will be	ober	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245447	B. WING	i		06/:	30/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279 F 280 SS=D	some missing teeth Assessment dated failed to identify mis observed R51's tee side of R51's mouth on the top gum line confirmed R51's ca missing teeth. On 6/29/16, at 1:15 stated if missing tee assessment and if a missing teeth shoul The facility Assess System-Care Plan a Conference-Interdis indicated Procedure assure that the follo and/or care planned e. Overall physical s 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in plannic changes in care and A comprehensive care within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter	and R51's Nursing 4/27/16, oral/dental status ssing teeth. At 3:16 p.m., RN-A th and confirmed, on the left n, R51 had one missing tooth and bottom gum line. RN-A re plan failed to include p.m., the director of nursing eth was identified on the an issue with the resident then d be on the care plan. ment and Care Plan and sciplinary, dated 1/5/16, e 5. The care plan team is to owing areas are addressed d. Completed by the facilitator. status. 0(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ng care and treatment or		279	made at that time if additional audit needed.	s are	7/27/16

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		AND HUMAN SERVICES & MEDICAID SERVICES			F OMI	FORM	09/14/2016 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			_E CONSTRUCTION (X	,	SURVEY PLETED	
		245447	B. WING	à		06/3	0/2016	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 280	legal representative and revised by a ter- each assessment. This REQUIREMEN by: Based on observat review the facility fa include anxiety sym and ongoing monito behaviors, goals wi for 1 of 5 residents unnecessary medio Findings included: R5's facility admiss of anxiety disorder. R5's quarterly Minir 3/20/16 included dia and demonstrated fi inattention, severe Brief Interview for M The MDS reported anti-anti-anxiety me look-back period. R5's current printer by the facility on 6/3 0.25 milligram (mg) for anxiety up to da	NT is not met as evidenced sident's family or the resident's am of qualified persons after NT is not met as evidenced sion, interview, and document field to revise the care plan to optoms treated with medication oring and target anxiety th individualized interventions (R5) reviewed for	F2	280		e Plan r view make e e to all vview ths of l ney		
	date of 3/23/16. The PRN order for Alpra 0.25 mg every nigh 5/11/16. Physician's	e orders further reflected the azolam was increased to give t for anxiety or dyspnea on s order also included vice a day for anxiety with a			reflects an appropriate diagnosis and behavioral symptoms and manageme for that resident. They will report the results of these audits at the October Committee meeting. The QA Comm will determine at that time if there is a	ent r QA nittee		

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		AND HUMAN SERVICES			FORM	09/14/2016 APPROVED 0938-0391				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED				
		245447	B. WING		06/3	30/2016				
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
SACRED	HEART CARE CENT	ER		AUSTIN, MN 55912						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE				
F 280 F 281 SS=D	and June 2016 refle Alprazolam 0.25 m twice-daily adminisi R5's current care p 6/30/16 did not ider lacked a plan of car monitoring and inter management. The identification of mor prescribed anti-anx During observation was resting in her b During an observat and at 1:26 p.m. R5 wheelchair. During an interview director of nursing of plan and indicated for anxiety and stat stated R5's care pla Facility policy Media reviewed 2/7/16 inco during the initial and incorporated into a reflects appropriate parameters for mor and ongoing need f but not limited to, w responsible fro mor when a re-evaluatio Facility policy Psych Procedure includeo sole approach for b interventions will be	ministration Record for May ected nightly administration of g (nightly after 5/11/16) and tration of Buspirone 15 mg. lan provided by the facility on ntify diagnosis of anxiety and re for anxiety target behavior erventions for symptom care plan also lacked nitoring and management of iety medications. s on 6/27/16, at 3:27 p.m. R5 bed with her eyes closed. ions on 6/28/16 at 8:42 a.m. 5 was sitting quietly in her on 6/28/16, at 2:20 p.m. (DON) reviewed R5's care there was not a plan of care ed there should be one. DON an would be updated today. cation Management Policy last cluded, "Information gathered d ongoing evaluations are comprehensive care plan that e medication-related goals and nitoring the resident's condition for medication(s), including, that is monitored, who will be nitoring, and how often and on is necessary." hotropic Medication Policy and d, "Medications use is not the behavioral intervention. Other e identified in the care plan." RVICES PROVIDED MEET	F 280			7/29/16				

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MEILTIF		<u>MB NO. 093</u> (X3) DATE SUR	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETE	
		245447	B. WING		06/30/20	016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COM	(X5) IPLETIO DATE
F 281	Continued From pa	age 15	F 28 ⁻	1		
	The services provid	ded or arranged by the facility ional standards of quality.				
	by: Based on observa review, the facility f grooming as direct of 1 resident (R70) living. Findings include: R70 had been obse and 6/28/16, at 1:4 black facial hair on R70 admitted to the diagnoses of deme and optic atrophy, a admission record. R70's Admission A dated 6/8/16 inform glasses for both dis indicated R70 reporelated to macular informed R70 had limitations and had During an interview licensed practical r residents do not ha family to bring one the facility had a co available if the resi During an interview stated R70's bath of Thursday evenings	NT is not met as evidenced tion, interview and record failed to complete facial ed in the initial care plan for 1 reviewed for activities of daily erved on 6/27/16, at 2:53 p.m. 7 p.m. R70 had long grey and the left side of her chin. e facility on 6/8/16 with entia, macular degeneration, according to the facility ssessment and Care Plan hed staff resident needed stance and reading and rited vision is worse at times degeneration. The assessment activities of daily living a self care deficit. y on 6/28/16, at 1:32 p.m. hurse (LPN)-B indicated if ave their own razors we contact in for them. LPN-B reported ommunity razor that was dent did not have one. y on 6/28/16, at 1:39 p.m. NA-B days were on Sundays and a. NA-B stated R70 was ndent and puts on her light		R70 was described as independen cares. NA-C immediately removed hair from R70 s chin when it was n known to her that the resident want removed. However, NA-C describe process as using a tweezers to rem three hairs from the resident s chir of which exceeded one-fourth inch length not really consistent with th deficiency description as long grey black facial hair. A razor was purch for R70. Nursing Assistant meetings be held during the week of July 25- nursing assistants will be reeducate the need to monitor facial hair, ever resident is otherwise independent. The QA Coordinator, or her designed audit facial grooming for at least on resident on each wing weekly for fo weeks (does not have to be the sam residents each week). If grooming not meet a professional standard, the responsible nursing assistant will be directed to offer additional grooming resident, including removal of chin for QA Coordinator will report results of at the first QA meeting following the completion of the audits. Need for continued audits will be determined meeting.	the nade ed it ed the nove n, none in ne and ased s will 29 and ed on n if the ee, will e ur ne does he e g to the nairs. f audits e	

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	09/14/2016 APPROVED 0938-0391			
STATEMENT OF DEFICI AND PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED			
		245447	B. WING _		06/;	30/2016			
NAME OF PROVIDER (OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
SACRED HEART (CARE CENT	ER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912						
PREFIX (EAC	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE			
up her w NA-B ex families or two s stated if then we NA-B we or they of notify so in their a there wa be docu was not have a of control p contami During a at 1:52 p is remove asked F husband tweezer facial ha the facia remove asked F husband tweezer facial ha the facia remove	splained if r need to bri trands then residents of notify the r ent on to ex- do not bring boat service account to g as not mone- imented in f shaved. Na- community purposes an ination betw an observat purposes an ination betw an observat ported the d if R70 wa 870 if she h d usually re is. R70 state an interview of nursing e a commune- s and we re the razors. bring one in t account. En-	age 16 s in her bathroom sink for her. esidents have facial hair, ing in razors or if they have one newe just pluck them out. NA-B did not have their own razors hurse and they call the family. cplain if the family is not around g a razor in then we would es to see if there is any money get one. NA-B stated then if ey in the account then it should the record why the resident A-B reported the facility did not razor because of infection nd possibility of cross ween residents. tion and interview on 6/28/16, indicated residents facial hair ay with cares. NA-C brought om from the dining room area. hair on R70's chin should be nted it to be removed. NA-C ad a razor. R70 indicated her moved the facial hair with a ed she was not able to see the of her vision and did not want there and wanted someone to en removed the facial hair. (DON) stated, the facility does nity razor for infection control equest family members DON explained if the family then facility would check the DON explained shaving the included in the care plan, the care plan, and if the	F 28						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 093								
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED		
		245447	B. WING		06/:	30/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 281 F 282 SS=D	resident was not sh documented in the 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided b	aved the reason should be record. RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in	F 281 F 282			7/29/16		
	accordance with ea care. This REQUIREMEN by: Based on observat review, the facility fa grooming as care p observed for activiti Findings include: R5 had been obserr and 6/28/16, at 8:42 black/grey facial ha R5's quarterly Minin 3/30/16 indicated se with a Brief Intervier score of 4 and exte staff members for p R5's care plan inclu in areas of dressing related to mild cogn plan directed, "staff During an interview nursing assistant (N	AT is not met as evidenced ion, interview and record ailed to complete facial hair lanned for 1 of 1 resident (R5) es of daily living. ved on 6/27/16, at 3:27 p.m. 2 a.m. R5 had long thin ir on her chin and upper lip. num Data Set (MDS) dated evere cognitive impairment w for Mental Status (BIMS) nsive physical assist from two personal hygiene. ded R5 had a self-care deficit i, bathing, and grooming litive impairment. The care		As stated by LPN-B, facility had contacted R5 s son multiple times request a razor for the purpose of removing facial hair from resident. (Facility does not have a razor for u multiple residents.) Son had stated had always had facial hair and it did bother her. He did, however, bring to the facility on 6/30/2016 and it is used as needed. Previously, he was sometimes bring a razor with him d visit and would shave his mother hi He did not, however, leave the razor the facility for daily use. Nursing Assistant meetings will be f during the week of July 25-29 and r assistants will be reeducated on the to take if a resident does not have a for facial grooming. Applicable faci policies have been updated to inclu recognition of shaving preferences procedures. The QA Coordinator, or her designed	ise on I R5 dn t a razor being buld uring a mself. or at held hursing e steps a razor lity de and			

Facility ID: 00393

	COF DEFICIENCIES	& MEDICAID SERVICES	(X2) MELT				0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245447	B. WING _			06/3	80/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SACREE	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 282	could wash her fac take care of nails a residents should be day. NA-C stated it shaved in a while a explained the facili bring in a razor. NA facility had a comm During an interview licensed practical r residents do not ha family to bring one the facility had a co available if the resi reported multiple a family to bring in w During an interview director of nursing not have a commu purposes and we r provide the razors. did not bring one in resident account. If preferences should staff should follow resident was not sh documented in the Facility policy Activ Functions) last revi "The purpose of ac provide assistance functions. To super to maintain optimu possible, and to re- life function. The purpose	e, and arms. NA-C stated "We and facial hair." NA-C stated e checked for facial hair every clooked like R5 had not been and needed to be done. NA-C ty has attempted for family to A-C reported she thought the nunity razor. o on 6/28/16, at 1:32 p.m. hurse (LPN)-B indicated if ave their own razors we contact in for them. LPN-B reported ommunity razor that was dent did not have one. LPN-B ttempts had been made for orking razors. o on 6/29/16, at 12:45 p.m. (DON) stated, the facility does nity razor for infection control equest family members DON explained if the family o then facility would check the DON explained shaving d be included in the care plan, the care plan, and if the naved the reason should be	F 28	82	audit personal grooming for at least resident on each wing weekly for fo weeks (does not have to be the sar residents each week). If adequate grooming has not been completed, responsible nursing assistant will be directed to offer additional grooming resident, including removal of chin h The QA Coordinator will review the plan and notify the Clinical Manage shaving preference was not include the care plan. QA Coordinator will n results of audits at the first QA mee following the completion of the audi The need for continued audits will b determined at that meeting.	ur ne the g to the nairs. care r if d on report ting ts.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APP CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093								
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245447	B. WING		06/3	30/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 282	procedures." Facility policies AM Cares, and Hair Ca	(Morning) Care, HS (bedtime)	F 28	2				
F 312 SS=D	procedures. 483.25(a)(3) ADL C DEPENDENT RES A resident who is un daily living receives	ARE PROVIDED FOR	F 312	2		7/29/16		
	by: Based on observat review the facility fa assistants for a dep the care plan for 1 of activities of daily livit Findings included: R5 had been observ and 6/28/16, at 8:42 black/grey facial ha R5's quarterly Minin 3/30/16 indicated se with a Brief Interview score of 4 and exte staff members for p R5's care plan inclu	ved on 6/27/16, at 3:27 p.m. 2 a.m. R5 had long thin ir on her chin and upper lip. num Data Set (MDS) dated evere cognitive impairment w for Mental Status (BIMS) nsive physical assist from two		As stated by NA-C, facility had con R5 s son multiple times to request razor for the purpose of removing fa hair from resident. (Facility does no a razor for use on multiple residents Son had stated R5 had always had hair and it didn t bother her. He di however, bring a razor to the facility 6/30/2016 and it is being used as n At meetings on 7/20/2016, nurses w reeducated on procedures to take in resident is in need of a razor and w reminded that there is no such thing "community razor." They were also informed to contact the Clinical Mar or DON if families do not respond to requests for a razor. Applicable fact policies have been updated to inclu recognition of shaving preferences	acial acial thave s.) facial d, / on eeded. were f a ere g as a) nager o ility de			

Facility ID: 00393

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TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	0938-039 SURVEY PLETED
		245447	B. WING	۵	06/	30/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/3	50/2010
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 312	related to mild cogr plan directed, "staff During an interview nursing assistant (N days were Thursda could wash her face breasts. NA-C state facial hair." NA-C state facility has attempte NA-C reported she community razor. During an interview director of nursing on have a commun purposes and we re provide the razors. did not bring one in resident account. D preferences should staff should follow to resident was not she documented in the Facility policy Activi Functions) last revi "The purpose of ac provide assistance functions. To super to maintain optimur possible, and to re- life function. The por	nitive impairment. The care shave resident." on 6/28/16, at 1:26 p.m. NA)-C reported R5's shower y evenings, and indicated R5 e, arms and underneath her ed "we take care of nails and stated residents should be hair every day. NA-C stated it not been shaved in a while lone. NA-C explained the ed for family to bring in a razor. thought the facility had a on 6/29/16, at 12:45 p.m. (DON) stated, the facility does hity razor for infection control equest family members DON explained if the family then facility would check the DON explained shaving be included in the care plan, he care plan, and if the naved the reason should be record. ties of Daily Living (Daily Life ewed on 1/5/16 included, tivities of daily living is to to resident for daily life vise resident activities in order n functions as long as educate in techniques of daily	F 31	procedures. Nursing Assistant meetings will be during the week of July 25-29 and assistants will be reeducated on th grooming practices, the steps to ta resident does not have a razor for grooming, and will be reminded th is no such thing as a "community of The QA Coordinator, or her design audit the care plan and personal appearance of at least one resider each wing weekly for the next four (does not have to be the same reseach week) to determine if facial grooming is being completed as care-planned. If not, the responsil nursing assistant will be directed thacial grooming to the resident. The Coordinator will review the care planotify the Clinical Manager if shave preference was not included on th plan. QA Coordinator will report raudits at the first QA meeting follo completion of the audits. The nee continued audits will be determine meeting.	nursing horough ake if a facial at there razor." hee, will ht from weeks bidents ole o offer he QA an and ng e care esults of wing the d for	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM AP CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09							
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATI	E SURVEY PLETED	
		245447	B. WING		06/:	30/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	Facility policies AM Cares, and Hair Ca requirements for en procedures.	(Morning) Care, HS (bedtime) re did not include suring shaving preferences or	F 312				
F 329 SS=D	483.25(I) DRUG RE UNNECESSARY D	EGIMEN IS FREE FROM RUGS	F 329			7/19/16	
	unnecessary drugs drug when used in of duplicate therapy); of without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above. The ensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug by to treat a specific condition documented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by: Based on observat review, the facility fa	NT is not met as evidenced ion, interview and record ailed to identify specific target hine efficacy for the use of an		R57 s target behavior of making s comments was being monitored by and Risk Management Committee.	nurses		

Facility ID: 00393

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	TIPLE CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED	
		245447	B. WING			30/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
SACRE	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 329	5 residents (R57) r medications. Findings include: R57's admission re- indicated that the r post-traumatic stre disorder, mild cogr disorder, depender generalized anxiety R57's physician ord that the resident ha Risperidone (an an (milligrams) to be t related to major de R57 had been pres antianxiety medica to take 0.5 mg by r to generalized anxi R57's quarterly Mir 2/24/16, indicated to cognitively intact. R57's psychoactive dated 5/24/16, indic taking 0.5 mg of At addition to Risperd stated that she suff	ecord, dated, 9/25/2014, esident had diagnoses of ss disorder, major depressive hitive impairment, panic nt personality disorder and y disorder. ders, dated, 8/27/15 indicated ad been prescribed httpsychotic medication) 2 mg aken by mouth at bedtime pressive disorder. In addition, scribed Lorazepam (an tion), dated 11/13/15. She was nouth three times a day related	F 3	 29 Communication to nursing target behavior for R57 and documentation by nurses limproved by adding target R57 to the electronic Point (completed every shift by leectronic Medication Adm Record (completed every signal of the anged to hallucinations. Psychotropic Medication Freviewed and updated by simembers of the Risk Man Committee will continue to behaviors, gradual dose repsychotropic medication uresidents at least monthly. been reviewed for all resid appropriate identification of behaviors Clinical Manager RN-B will documentation of target behaviors 	d has been behavior for t of Care VA s) and the inistration shift by nurses). or for R57 was The Policy was several agement agement monitor target eductions, and se for all These have ents to ensure of target		

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/14/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		245447	B. WING			06/;	30/2016	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SACRED	HEART CARE CENT	ER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329	 8/27/15 with new or not have any suicid recommended to cor R57's medication a reviewed from 6/1/1 that the resident ha Risperdal as prescr R57's care plan, da resident had a pote to diagnoses of any dependent personal lengthy psychologic stays in a behaviora history of electrocor suicidal ideation. R5 health which R57 re a history of tongue thrusting the lower the staff to monitor in her mood and ad care plan also reco psychological media facility policy. It adv hallucinations, delu she had a plan to cor R57's doctor's prog stated that the resid psychiatrically which psychopharmathera that something mus polypharmacy. 	hitted back to the facility on ders for Risperdal. R57 did al comments this month. It pontinue to same plan of care. dministration record (MAR), 3 through 6/30/16, indicated d been taking the Ativan and ibed. ted 10/3/2014, stated that the ntial for altered mood related tiety, depression, panic and lity disorder. R57 had a sal history with prior hospital al healthcare unit and had a nvulsive treatment along with 57 was followed by mental eported as beneficial. R57 had thrusting and sucking and lip. The care plan encouraged R57 for changes and declines dress them as needed. The mmended to monitor her cation as directed by the ised to question R57 about sions, wanting to die and if	F3	329				

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		AND HUMAN SERVICES				FORM	09/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING	i		06/;	30/2016
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	that when she was herself from human When interviewed of nursing assistant (N behaviors and moo instructed to notify of document. NA-F sta angry if someone w stated that R57 did roommate and wou been resolved. Whe isolate herself, NA- tendency to isolate she saw R57 isolate week. When asked NA-F stated no but when R57 had gone seeing things and ta When interviewed of NA-G was asked w been instructed to r to document. NA-G any behaviors that stated that she did R57 did not exhibit tended to isolate he isolated herself. Wh hallucinations or de well. When interviewed of NA-H stated that she any behaviors such or delusions. NA-H heard that R57 was thoughts of killing h	anxious she tended to isolate a company. on 6/29/16 at 1:32 p.m. NA)-F was asked what target d symptoms she had been the nurses in order to ated that R57 would get very vere to call her a man. NA-F not get along with a previous Id say things but that had en asked if R57 did tend to F stated that R57 did have a herself a lot. NA-F stated that e herself once or twice a if R57 had any hallucinations, stated a couple months ago e to the hospital she was	F	329			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/14/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245447	B. WING	i		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 25	F:	329			
	registered nurse (R psychiatrist had pre- the Risperdal. R57's not prescribe these asked what specific staff had been mon- two medications we stated R57 had been suicidal comments. started on Risperda she had been in the the Ativan had not b just prescribed. RN on the medication p When asked what r anxiety R57 had ex would make freque which was due to he When interviewed of stated that R57 had stated that R57 had features. She stated on Risperdal and ca interdisciplinary tea behaviors. She state that R57 had exhibi had made a suicida staff had started mod When interviewed of director of nursing (lack of mood and b said that they shoul monitored. Review of the Psyc	on 6/30/16 at 12:30 p.m., RN- I never exhibited psychotic d when R57 had been placed ame back to the facility, the m (IDT) had reviewed her ed at the time the only thing ted was that one time R57 I comment and so the nursing					

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED	
		245447	B. WING		06/30/2016	
NAME OF I	PROVIDER OR SUPPLIER					
SACRED	HEART CARE CENT	ER				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 329	from unnecessary of unnecessary drugs without adequate n medication was init resident was monit effectiveness of the	age 26 s drug regimen must be free medications. It identified as any medication used nonitoring. When antipsychotic iated, it stated that the ored to determine the e medication. Behaviors were on the behavior documenting	F 32	9		
F 334 SS=E	IMMUNIZATIONS The facility must de that ensure that (i) Before offering t each resident, or the representative rece benefits and potent immunization; (ii) Each resident is immunization Octoor annually, unless the contraindicated or the contraindicat	eives education regarding the tial side effects of the offered an influenza ber 1 through March 31 e immunization is medically the resident has already been	F 33	4		7/21/16
	representative has immunization; and (iv) The resident's in documentation that following: (A) That the reside representative was the benefits and po- immunization; and (B) That the reside influenza immunization;	the resident's legal the opportunity to refuse medical record includes t indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the ation or did not receive the ation due to medical				

Facility ID: 00393

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		E SURVEY IPLETED
		245447	B. WING	·	06/	30/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
F 334	Continued From pa	ge 27	FS	334		
	that ensure that (i) Before offering the immunization, each legal representatives the benefits and po- immunization; (ii) Each resident is immunization, unless medically contrained already been immu (iii) The resident or representative has immunization; and (iv) The resident's representative has immunization; and (iv) The resident's representative was the benefits and po- pneumococcal immediate (A) That the resider pneumococcal immediate pneumococcal immediate (v) As an alternative and practitioner reco- pneumococcal immediate years following the immunization, unless the resident or the re- refuses the second	a resident, or the resident's e receives education regarding tential side effects of the offered a pneumococcal ss the immunization is licated or the resident has nized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative				
	by:	NI IS NOT MET AS EVIDENCED				

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		& MEDICAID SERVICES	0.00		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245447	B. WING		06/3	30/2016
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE	E, ZIP CODE	
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHW AUSTIN, MN 55912	EST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 334	Continued From pa	ige 28	F 3	34		
	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.			As noted, all identified received the 23-valent polysaccharide vaccin been initial discussion the PCV13 vaccine. F and R35 (or responsib now received informat 13-valent pneumococc vaccine and have com form indicating their pr to receiving the PCV13 preference is to receiv information will be pas primary physician, who for determining the tim vaccination according recommendations and for the vaccination.	pneumococcal e and there had of the need to offer A3, R12, R38, R4, ble parties) have ion about the cal conjugate pleted a written reference in regard 3 vaccine. If their re PCV13, that esed on to their o will be responsible ning of the to CDC	
	indicated that the re Alzheimer's disease pulmonary disease R12's Immunization indicated that the re 23-valent pneumoc (PPSV23) but not the R38's Admission Re indicated that the re cognitive impairment R38's Immunization (12/1/2009), indicated received the 23-val	n Report, dated 5/7/2011, esident had received the occal polysaccharide vaccine he PCV13. ecord, dated 3/2/2012, esident had a diagnosis of mild nt. n Report, dated historically red that the resident had		The immunization reco will be reviewed in com next scheduled physic Information about PCV has not yet received it responsible parties by when she gives notific date of the next sched The form indicating ac declination of PCV13 r before the physician ca The Director of Nursin of existing residents w received the PCV13 va information to the Rou further action as descr residents will receive t admission. The DON	ijunction with their ian visit. /13, if the resident , will be given to the Rounds Nurse ation to them of the uled physician visit. cceptance or must be completed an address it. g will compile a list ho have not accine and give the inds Nurse for ribed above. New his information at	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 09/14/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245447	B. WING		06	/30/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST JUSTIN, MN 55912	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	indicated that the redementia and cardi R4's Immunization (4/1/2002), indicate received the 23-val- polysaccharide vac second PPSV23 on PCV13. R35's Admission Re indicated that the rediabetes, heart faile disease. R35's Immunization (11/1/2011), indicate received the 23-val- polysaccharide vac PCV13.	cord, dated 10/26/2015, esident had diagnoses of omyophathy. Report, dated historically d that the resident had ent pneumococcal cine (PPSV23). R4 received a 12/15/2009 but not the ecord, dated 11/11/2014, esident had diagnoses of: are and chronic kidney n Report, dated historically ed that the resident had ent pneumococcal cine (PPSV23) but not the	F3	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	director of nursing s about the new requivaccine to residents had not yet begun t Medical Director has stated that they hav it yet but it was goin 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c	on 6/30/16 at 2:37 p.m., the stated that she started hearing irements to offer the PCV13 is last year. She stated that she o push the policy yet but the d begun talking about it. She yen't begun instituting offering ing to be in the works. I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.	F 4	141		7/21/16

Facility ID: 00393

If continuation sheet Page 30 of 34

		AND HUMAN SERVICES				FORM	09/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		(X3) DATE	E SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING _		COM	PLETED
		245447	B. WING			06/:	30/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 00 12TH STREET SOUTHWEST		
SACRED	HEART CARE CENT	ER			JSTIN, MN 55912		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE
F 441	Continued From pa	ge 30	F 4	441			
	(a) Infection Contro						
	Program under whi	tablish an Infection Control ch it -					
		ntrols, and prevents infections					
	(2) Decides what pr	rocedures, such as isolation,					
		o an individual resident; and or incidents and corrective					
	actions related to in						
	(b) Preventing Spre						
		ion Control Program esident needs isolation to					
	prevent the spread	of infection, the facility must					
	isolate the resident. (2) The facility must	t prohibit employees with a					
	communicable dise	ase or infected skin lesions					
	direct contact will tra	with residents or their food, if ansmit the disease.					
		t require staff to wash their rect resident contact for which					
	hand washing is inc	dicated by accepted					
	professional practic	;e.					
	(c) Linens	adle stare presses and					
	transport linens so a	ndle, store, process and as to prevent the spread of					
	infection.	▼					
	This REQUIREMEN	NT is not met as evidenced					
	by: Based on interview	v and record review, the facility			Facility would like to note that cellu	ilitie je	
	failed to track and the	rend ongoing infections to			a non-contagious condition and pos	sed no	
		ducation was necessary to This included review of R35			potential threat to other residents, s visitors.	staff, or	
		on recorded on the April 2016					

Facility ID: 00393

If continuation sheet Page 31 of 34

		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245447	B. WING _		06/3	30/2016	
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWES AUSTIN, MN 55912	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 441	Continued From pa	ae 31	F 44	41			
F 441	infection log. This h residents, staff and Findings include: R35 was included of with diagnosis of C included antibiotic of days. Start date 4/5 no other information antibiotic was affect cleared. There was staff was given due Review of the facility for All Nursing Units contained a total ar month. Infections we the facility which ide infection was located all three months on received antibiotics antibiotics, and start antibiotics. The infe- residents who had treated with an anti- of infection trends a facility acquired infe- did not reflect docu- measures to stop o- infections that had April, May and June	ad the potential to effect all visitors.		 Facility uses colored coor to assist in tracking infection assist in tracking information and the present in the facility, which resident is receiving an a on this information a det be made to increase har washing audits, to provide education to staff, or to contract the progress nor resident is receiving an a facility has multiple polic related to infection contract hand-washing, universal procedures for cleaning equipment, etc. The Information contract infection control procedures in the assessment of trend preventative measures. The Administrator will rebefore the next quarterly 	ctions and infections exist. en morning report on related to ions of infections nether or not the antibiotic. Based ermination may de additional contact Medical ble need for nplete infection tes when a antibiotic. The ies in place ol, such as precautions, and disinfecting ection Control ations of nursing ares to monitor ares. these practices, n infection log, d documenting s or the need for		
	infection control nu residents were mor on antibiotics. She	on 6/30/2016 at 2:08 p.m., the rse, (LPN)-A stated that nitored when they were placed stated that the infection should n they were given the last dose		meeting and will discuss what changes, if any, mi The DON will report on t any problems or challen	ght be made. he progress and		

Facility ID: 00393

If continuation sheet Page 32 of 34

		AND HUMAN SERVICES		FC	ED: 09/14/2016 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245447	B. WING		06/30/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SACRED	HEART CARE CENT	ER		200 12TH STREET SOUTHWEST AUSTIN, MN 55912	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 441	Continued From pa writing in an infection was resolved or not	on note whether the infection	F 441	next quarterly Quality Assurance meeti	ng.
F 520 SS=C			F 520		7/19/16
	assurance committe nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the	C		
	committee meets a issues with respect and assurance activity develops and imple action to correct ide	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ments appropriate plans of entified quality deficiencies. retary may not require			
	disclosure of the re except insofar as si	cords of such committee uch disclosure is related to the committee with the			
		s by the committee to identify deficiencies will not be used as is.			
	by: Based on interview	NT is not met as evidenced and document review, the ure the medical director, or		It has proven difficult at times for the Medical Director to attend all QA meeti	ngs

Facility ID: 00393

If continuation sheet Page 33 of 34

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · /	SURVEY PLETED
		245447	B. WING			06/3	30/2016
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SACREE	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST NUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 520	assessment and as of 4 quarterly QAA Findings include: Review of the facili records, reviewed f revealed the medic meeting held on 7/ 4/11/16 (a period o attendance records attended the QAA f 11/9/15 and 1/18/19 On 6/30/16, at 2:07 coordinator (QAC)- director had not att required quarterly. tried to coordinate medical director wa he can be present. physician was press director. The QAC Medical Director wa The facility policy, to individuals will serve	an, attended quality ssurance (QAA) meetings for 3 meetings. ty's QAA meeting attendance from 7/13/15 to 4/11/16, cal director attended the QAA 13/15 and not again until f nine months). The s revealed no physician meetings held on 9/28/15,	F 5	20	since his time to see residents and accomplish other tasks is limited. However, he reads the Minutes from meeting he was not able to attend easily contacted for input about an quality issues. After the survey, th Coordinator contacted the Medical Director to develop a plan to impro- attendance at QA meetings. This more communication regarding his scheduled time in Austin and the possibility of his attending through if necessary.	om any and is y e QA ove his involves	

Facility ID: 00393

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POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REV	ISIT
	B. Wing	Y2	8/13/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED HEART CARE CENT	ER	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).

ITE	Μ		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			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	0(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), 48 (2)	83.10(k)	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	(1)	Completed	Reg. #	483.25(n)		Completed
LSC			07/29/2016	LSC			07/19/2016	LSC			07/21/2016
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.65		Completed	Reg. #	483.75	(0)(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			
REVIEWE		REVIEW (INITIAL		DATE		SIGNATURE OF	SURVEYOR			DATE	
		GPN		9/14/20	16		101	60		8/13	/2016
REVIEWE CMS RO		REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOW 6/30/201	UP TO SURVE 6	YCOMPL	ETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?							



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.

Sacred Heart Care Center September 14, 2016 Page 2

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.

Sacred Heart Care Center September 14, 2016 Page 3

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

MEDICARE/MEDICAD CERTIFICATION AND TRANSMITTAL PART 1 - TO BE COMPLETED BY THE STATE SURVEY ACENCY Dis: LGO9 Radiily D: 00393 1. MEDICARE/MEDICAD PROVIDER NO.(L1) 3. NAME AND ADDRESS OF FACILITY (L3) SACRED HEART CARE CENTER (L4) 2102 12TH STREET SOUTHWEST 4. TYPE OF ACTION: [1.6] 0120 12TH STREET SOUTHWEST 1. Initial 2. RecentInation 2. STATE VENDOR OR MEDICAID NO. (L3) (L3) 1201 12TH STREET SOUTHWEST 1. Initial 2. RecentInation 4. CIOW 5. DIFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 7. PROVIDER/SUPPLIER CATEGORY 92. (L7) 8. Full Survey After Complaint 6. DATE OF SURVEY 08/13/2016 ^{1.34} 09 SNFN7/Dail of 9 SNR 04 PRT 10 NF 14 CORF 9. ACCREDITATION STATUS (L10) 95 SNFN7/Dail of 9 SNR 16 HOSPICE 09/30 0. Unaccredited 1 TC 04 SNF 08 OPT/SP 12 RIC 16 HOSPICE 09/30 10. LTC PERIOD OF CERTIFICATION 1 10. THE FACILITY IS CERTIFIED AS: A. In Compliance With 2 AGON A. In Compliance With 2 Organic Requirements: A Conceptiance SP A. In Compliance With 2. State SURVEY AGENCY MEMORY B. Not in Compliance With Program 2. Centenic PENDANCE Medical Director 12. Total Facility Beds 59 (L13) B. Not in Compliance W	DEPARTMENT OF HEALTH AND HUMA	N SERVICES	CENTERS FOR MED	DICARE & MEDICAID SERVICES
1. MEDICARE/MEDICAID PROVIDER 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7(4.5) NO.(L1) 245447 (L4) 1200 12TH STREET SOUTHWEST 4. TYPE OF ACTION: 7(4.5) (L2) 935742400 (L5) AUSTIN, MN (L6) 55912 3. Termination 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L5) AUSTIN, MN (L6) 55912 5. Validation 5. Validation (L9) 04 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLA 8. Full Survey After Complaint 0. Duccerding 1 TIC 30 SNENF70stinet 07 XRay 11 CP/ID 16 ASC 99/30 10. LTC PERIOD OF CERTIFICATION 10 THE FACILITY IS CERTIFIED AS: AndOr Approved Waivers Of The Following Requirements: 09/30 11. LTC PERIOD OF CERTIFICATION 10 THE FACILITY IS CERTIFIED AS: AndOr Approved Waivers Of The Following Requirements: 0. Stope of Services Limit 12. Total Facility Beds 59 (L18) 13. Not in Compliance with Program Requirements: -2. Technical Personnel 6. Scope of Services Limit 13. Total Facility Beds 59 (L19) 14. ECCEPTIFICATION 15. FACILITY MEETS 14. LTC CERTIFIED BED BREAKDOWN 18. SNATE SURVEY AGENCY APPROVAL 9. Beds/Room 1				ID: LKO9
NO.(1.) 245447 (1.3) SACRED HEART CARE CENTER 1. Initial 2. STATE VENDOR OR MEDICAID NO. 1. Initial 2. STATE VENDOR OR MEDICAID NO. 1. Initial 2. Recritification (1.2) 935742400 (1.5) AUSTIN, MN (1.6) 55912 3. Vernimution 4. CHOW (1.9) 0.5) AUSTIN, MN (1.6) 55912 5. Solidation 4. CHOW (1.9) 0.5) AUSTIN, MN (1.6) 07 DER/SUPPLIER CATEGORY 0.2 (1.7) 6. DATE OF SURVEY 08/13/2016/1.24) 08 HIA 09 ESRD 13 PTP 22 CLIA 8. Full Survey After Complaint 0 0.0 CREDITION STATUS:	PART I -	TO BE COMPLETED BY THE STAT	TE SURVEY AGENCY	Facility ID: 00393
2. STATE VENDOR OR MEDICAID NO. (L4) 1200 12TH STREET SOUTHWEST 3. Termination 4. CHOW (L2) 935742400 (L5) AUSTIN, MN (L6) 55912 3. Termination 4. CHOW 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02_{-} (L7) 8. Full Survey After Complaint 7. On Site Visit 9. Other 6. DATE OF SURVEY 08/13/20116 ^{1,24} 02 SNFNF/Dual 06 PRTF 10 NF 14 COFF 95 SRC 13 PTP 22 CLA 8. Full Survey After Complaint 9. Sock Provide Com				_
5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 92 (1.7) 8. Full Survey After Complaint (1.9) 01 Hospital 05 HHA 09 ESR0 13 PTIP 22 CLA 8. Full Survey After Complaint 6. DATE OF SURVEY (8/13/2016/L34) 09 SNFAF/Distinct 07 X.Ray 11 CF/IDI 15 ASC FISCAL YEAR ENDING DATE: (1.3) 0. Unaccredited 1 TIC				3. Termination4. CHOW5. Validation6. Complaint
6. DATE OF SURVEY 08/13/2016 $13/2$ $0^{2.34}$ $0^{2.35}$ SNF/NF/Dual 0^{6} PRTF 10 NF 14 CORF 15 ASC FISCAL YEAR ENDING DATE: (1.35) 0 Unaccredied 1 TUC (1.0) 0^{4} SNF 0^{6} OPT/SP 12 RNC 16 HOSPICE $0^{9/30}$ $0^{9/30}$ 11. LTC FERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With			× ,	
8. ACCREDITATION STATUS: (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC FISCAL YEAR ENDING DATE: (L25) 0 Unaccredited 1 TIC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE 09/30 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: 0. Scope of Services Limit To (b): X Program Requirements 2. Technical Personnel 6. Scope of Services Limit 12. Total Facility Beds 59 (L18)		•		
$\begin{array}{c c c c c c c c c c c c c c c c c c c $		03 SNF/NF/Distinct 07 X-Ray 11 ICF/III		FISCAL YEAR ENDING DATE: (L35)
From (a): To (b):A. In Compliance With Program Requirements Compliance Based On: $_12.$ Total Facility BedsA. In Compliance With Program Requirements Compliance Based On: $_1.$ Acceptable POCAnd/Or Approved Waivers Of The Following Requirements: $_2.$ Technical Personnel $_6.$ Scope of Services Limit $_3.$ 24 Hour RN $_7.$ Medical Director $_4.$ 7-Day RN (Rural SNF) $_8.$ Patient Room Size $_5.$ Life Safety Code $_9.$ Beds/Room12. Total Facility Beds59 (L18) 59 (L17)B. Not in Compliance with Program Requirements and/or Applied Waivers: $Requirements and/or Applied Waivers:_7. Medical Director_4. 7-Day RN (Rural SNF)_8. Patient Room Size_5. Life Safety Code_9. Beds/Room14. LTC CERTIFIED BED BREAKDOWT18 SNF19 SNF19 SNFICFIID14. LTC CERTIFIED BED BREAKDOWT59(L37)ICFIID15. FACILITY MEETS1861 (e) (1) or 1861 (j) (1):(L15)(L15)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):Date:Not in Compliance With CANCELLATION DATE):18. STATE SURVEY AGENCY APPROVALDate:17. SURVEYOR SIGNATUREDate:08/16/2016(L19)08/16/2016(L19)18. STATE SURVEY AGENCY APPROVALDate:$		04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	09/30
To(b):XProgram Requirements Compliance Based On: $_$ 1. Acceptable POC2. Technical Personnel $_$ 6. Scope of Services Limit $_$ 3. 24 Hour RN $_$ 7. Medical Director $_$ 4. 7-Day RN (Rural SNF) $_$ 8. Patient Room Size $_$ 5. Life Safety Code $_$ 9. Beds/Room12. Total Facility Beds59(L18)13. Total Certified Beds59(L17)14. LTC CERTIFIED BED BREAKDOWN $18 SNF$ 19 SNF19 SNF15. Solution19 SNF19 SNF16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):16. STATE SURVEY AGENCY APPROVAL16. STATE SURVEY OR SIGNATUREDate:17. SURVEYOR SIGNATURE08/16/2016 (L19)18. STATE SURVEY AGENCY APPROVAL18. STATE SURVEY AGENCY APPROVALDate:	11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:		
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $				
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	To (b):	riogram requirements		
12.Total Facility Beds 59 (L18)		*		
13.Total Certified Beds 59 (L17) B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12) 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15) 6. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 18. STATE SURVEY AGENCY APPROVAL Date: 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date: 6. Gary Nederhoff, Unit Supervisor 08/16/2016 (L19) Kamala Fiske-Downing. Health Program Representative 08/16/2016 (L20)	12.Total Facility Beds 59 (L18)	1. Acceptable POC		· _
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	17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
	Gary Nederhoff, Unit Supervisor	08/16/2016 (L19)	Kamala Fiske-Downing. Heal	th Program Representative $08/16/2016_{(L20)}$
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY	PART II - TO BE	COMPLETED BY HCFA REGIONAL	L OFFICE OR SINGLE S	FATE AGENCY
19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 21. 1. Statement of Financial Solvency (HCFA-2572)	19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Finan	cial Solvency (HCFA-2572)
RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 1. Facility is Eligible to Participate 3. Both of the Above :	1. Facility is Eligible to Participate	RIGHTS ACT:		
2. Facility is not Eligible	, , , ,			
(L21)				
22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30)	22. ORIGINAL DATE 23. LTC AGREEM	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNING DATE ENDING DATE <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u>	OF PARTICIPATION BEGINNING	DATE ENDING DATE	VOLUNTARY 00	INVOLUNTARY
03/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety	03/01/1987		01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41) (L25) 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement	(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 03-Risk of Involuntary Termination OTHER	25. LTC EXTENSION DATE: 27. ALTERNATI	VE SANCTIONS		n <u>OTHER</u>
A. Suspension of Admissions: 04-Other Reason for Withdrawal 07-Provider Status Change	A. Suspension	n of Admissions:	04-Other Reason for Withdrawal	-
(L27) P. Passind Suspension Date:	(L27) D D D · 10			00-Active
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03001				
(L28) (L31)	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE	31. RO RECEIPT OF CMS-1539 32	. DETERMINATION OF APPROVAL DATE		
(L32) (L33) DETERMINATION APPROVAL	(L32)	(L33)	DETERMINATION APPR	ROVAL



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,

Kumala Fiske Downing

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



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 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,

Kumala Fiske Downing

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		C	DATE OF REVIS	IT
	B. Wing	Y2	2 8	3/13/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
SACRED HEART CARE CENT	ER	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).

ITE	M		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0250		Correction	ID Prefix	F0272	2	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), 483.2	20(k)(1)	Completed	Reg. #	483.20 (2)	(d)(3), 483.10(k)	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	2	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 Reg. #	F0334 483.25(n)		Correction Completed	ID Prefix Reg. #	F0441 483.65		Correction	ID Prefix Reg. #	F0520 483.75(o)(1)		Correction Completed
LSC			07/21/2016	LSC			07/21/2016	LSC			07/19/2016
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AG		REVIEW (INITIAL	S)	DATE	10	SIGNATURE OF	SURVEYOR	101		DATE	
REVIEWE CMS RO		G REVIEW (INITIAL		8/16/20 DATE	16	TITLE		101	00	DATE	3/13/2016
FOLLOW 6/30/201	UP TO SURVE 6		ETED ON			R ANY UNCORREC					s 🗌 no

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		D	ATE OF REVIS	IT
	B. Wing	Y2	2 7/	/25/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
SACRED HEART CARE CENT	ER	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	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
NFPA 101 Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC K0018	07/06/2016	LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		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) 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 SURVE 6/29/2016	Y COMPLETED ON		R ANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567			S 🗌 NO

DEPARTMENT OF HEAL			D CERTIFIC	CATION A	CENTERS FOR MEI AND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: LK09
	PART I -	то ве сомрі	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00393
1. MEDICARE/MEDICAID PROVI NO.(L1) 245447	DER	3. NAME AND AL (L3) SACRED H	EART CARE	CENTER		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAI (L2) 935742400	D NO.	(L4) 1200 12TH S (L5) AUSTIN, M		THWEST	(L6) 55912	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 06 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/30/2016 ^(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds	59 (L18)	Compliance	ance With equirements e Based On: .cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
13.Total Certified Beds	59 (L17)	X B. Not in Con Requirements	and/or Applied V	-	* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKD	OWN	L			15. FACILITY MEETS	
18 SNF 18/19 SNF 59	5 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE		Date : 7	7/27/2016		18. STATE SURVEY AGENCY	Ith Program Representative $08/15/2016$
		COMPLETED	RY HCFA RF	(L19)	OFFICE OR SINGLE S	(L20)
19. DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible	ILITY Participate	20. COM	IPLIANCE WITH TTS ACT:		21. 1. Statement of Finan	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEM	1ENT	26. TERMINATION ACTION:	: (L30)
OF PARTICIPATION 03/01/1987	BEGINNINC	DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure 02 Dimension of the state of the	05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI A. Suspension	VE SANCTIONS a of Admissions:	(L25) (L44)		02-Dissatisfaction W/ Reimburst 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	8
(L27)	B. Rescind Su	spension Date:				
		D/000000000000000000000000000000000000	(L45)		00 DEM 1972	
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



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:

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

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

<u>Remedies</u> - 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;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 <u>Email: gary.nederhoff@state.mn.us</u> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumalu Piske Downing

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

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH			FORM	APPROVED
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		. 0938-0391 TE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			MPLETED
	245447	B. WING _		/30/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/2010
SACRED HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 COMMEN	TS	F 00	00	
as your allegation of Department's acce enrolled in ePOC, y at the bottom of the form. Your electrom be used as verifica Upon receipt of an on-site revisit of yo validate that substa	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with			
complaint investigat the time of the star investigation of cor completed and four F 250 483.15(g)(1) PROV SS=D RELATED SOCIAL The facility must pr services to attain o	nplaint H5447008 was nd not to be substantiated. /ISION OF MEDICALLY . SERVICE ovide medically-related social r maintain the highest I, mental, and psychosocial	F 25	50	7/19/16
by: Based on observa review, the facility f assess mood chan increase in depress	NT is not met as evidenced tion, interview, and document ailed to comprehensively ges after a substantial sive symptoms for 1 of 5 riewed for unnecessary		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.	
LABORATORY DIRECTOR'S OR PROVID Electronically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE 07/21/2016

Electronically Signed

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.

PRINTED: 07/27/2016

		AND HUMAN SERVICES				FORM	07/27/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (E SURVEY PLETED
		245447	B. WING			06/3	80/2016
	PROVIDER OR SUPPLIER	ER		12	TREET ADDRESS, CITY, STATE, ZIP CODE 200 12TH STREET SOUTHWEST USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 250	Findings included: R58 had been obse 6/28/16, at 9:03 a.m R58 was lying in be During an interview R58 was lying in be question, "I noticed a reason you like to don't know where to talk to people they li idiot." R58 stated s was then asked, "H depression?" R58 talk to me about it, After several more R58's sentence struc comprehendible for R58 had diagnoses disturbance, major restlessness and ag abnormal weight los admission record. R58's last Care Are 12/29/15 included, instrument for screa and measuring the of (04) remains low feeling tired (almos occasional down/sa with any of the rem medication therapy beneficial [Celexa, migraines but also Quetiapine]. No add with this review. Wi potential changes in address PRN [as m	erved on 6/27/16, at 3:07 p.m., n., and 6/29/16 at 11:00 a.m. ed awake. on 6/29/16, at 8:58 a.m. while ed awake. In response to the you stay in your room, is there o be alone?" R58 stated, "I o go or what to do and when I look at me like I'm a stupid cometimes she feels sad. R58 low do staff help you with your responded, "I suppose they but I don't know how often." minutes of conversation, ucture was not r meaning. of dementia with behavioral depressive disorder, gitation, anxiety disorder, and ss according to the facility ea Assessment performed on "PHQ-9 [a multipurpose ening, diagnosing, monitoring severity of depression] score to tall the time) and having ad days but denied difficulty aining items. Current for her depression remains Mirtazapine, Divalproex for used to control mood, and ditional issues or concerns II continue to monitor for n cognition and mood and	F 2	250	Another PHQ-9 was administered to on 6/29/16 with a resulting score of RN-A also initiated behavioral chartin every shift for R58. The physician we notified on 6/29/16 of the four most of scores on the PHQ-9. He expressed the PHQ-9 is not a valid assessmen instrument for nursing home resident with dementia, noting that staff observations are much better indication mood. He will see the resident on 7/19/2016 and determine at that time any treatment changes are warranted. The family was notified of the change the PHQ-9 scores on 6/29/16 as well the fact that nursing had not reported anything different about R58 is befat Daughter stated that family had also seen any change in mood. The behavioral progress note dated 5/11/16 stated in its entirety: The target behavior we are monitoring is Accu- staff of lying to her. In the month January, the target behavior did not In the month of February, again, the behavior did not occur. In the month March, the target behavior did occur and the month of April it occurred x 3 Facility does not agree that the phra- steady increase in behaviors fairly represents these minimal changes. R58 has been very pleasant during LSW is follow-up visits and no chan- have been noted that would validate results of the 6/22/16 PHQ-9 score.	10. ng on vas recent d that t tors of e if ed. ll as d aviors. o not get using of occur. target of x 1 3. se a	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	· · ·	E SURVEY PLETED
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		245447	B. WING		06/30/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CEN	TER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 250	Continued From p	age 2	F 2	50		
	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			No other residents were identified having a significant increase in a score without follow-up. If there is an increase in score or PHQ-9 that moves a resident to a level (there are a total of 5 levels) depression, the LSW will notify th Managers and DON of this chang LSW will check with nursing staff any changes in observed behavior document their impressions in a note. The LSW will talk to a fami member to notify them of the chan PHQ-9 score and to determine if family has noted any changes in resident s mood or behaviors. The will make a follow-up visit to the re within one week of the increased score and document her observat the resident s mood/behaviors.	PHQ-9 the different of e Clinical ge. The about or and will progress ly nge in the The LSW esident PHQ-9	
	indicating major de severe. The PHQ- thoughts of being k the days during the interest or pleasure day, feeling tired n down, depressed, the days. R58's physician or decrease Mirtazap medication) to 15 r R58's behavioral p 4/1/16-6/27/16. Pr delusional behavio reporting someone	arms with a score of fifteen epression or moderately 9 reported R58 now had better off dead half or more of e look back period, had little e in doing things nearly every early every day, and feeling and hopeless half or more of der dated 4/11/16 included ine (anti-depressant ng every bedtime. rogress notes reviewed from ogress notes reported r patterns such as resident e in her room and they were d reports of other people being		 When notified of an increase in leadepression, as measured by the the CM will review the resident as medications and behavioral chart or designee will notify the physicia will decide if any change in treatmer warranted. The LSW and CM will determine a need for increased visits from S Services or if a referral for psychis services should be considered. The Risk Management Committee continue to review target behavior least monthly during its weekly measurement warranted. 	PHQ-9, ing. CM an, who nent is if there is Social atric e will rs at	

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	TOF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	TIPLE CONSTRUCTION		<u>0938-039</u> E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED	
		245447	B. WING _		06/	06/30/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
SACREE	HEART CARE CENT	ER		1200 12TH STREET SOUTHWES AUSTIN, MN 55912	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 250	5/11/16 reflected a behavior of "accusi January through Ap R58's physician vis included, "Nursing problems. Her hust does not remembe depression likely to note indicated R58 to dementia howev Divalproex (mood a decreased from 12 a day to 125 mg tw loss as a possible a R58's social service a.m. included, "RE PHQ-9 score of (15 decline in mood, sin so vocal during our was able to stay on one of the items re responses. She rea interest in doing thi eyesight/hearing pe frustrated & depres tired on a daily bas difficulty concentrat dead. "They can jus wait for me to die" v denied any potentia and went on to stat has likely had these months, but per rec has consistently de asked. [R58] contir of her time resting i	steady increase in target ng staff of lying to her" from oril 2016. it progress note dated 5/17/16 staff indicates no new band recently died, which she r." Physician note identified be mild. Physician progress had weight loss likely related er, physician indicated the altering medication) was 5 milligrams (mg) three times ice per day related to weight adverse drug reaction. es note dated 6/22/16, at 11:35 [regarding] mood: Today's 5) does show a significant mply for the fact that she was visit with how she feels. [R58] task and respond to every mood, and with quite detailed adily admitted to little/no ngs (d/t [due to] poor er her comment), frequently ised, occasional insomnia, is, feeling bad about herself, ting, and thoughts re better off st throw a sheet over me and was her exact response. She al for self-harm when asked, e "that just isn't me." "[R58] e feelings over the past several cent resident interviews, she nied them when specifically uses to spend a good majority in bed. This is per her choice, for well over the past year, but	F 2	50 The DON will review the residents who have been having a change in level measured by the PHQ-9 follow-up was completed She will present the resu at the next two Quality A Committee meetings. A the need for continued a at that time.	n identified as of depression as to determine if d as described. ults of her audits ssurance A decision as to		

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		AND HUMAN SERVICES				FORM	: 07/27/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245447	B. WING			06/	/30/2016
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 250	personal attention. time. Will continue to changes in cognition needed]." R58's record lacked assessment followin depressive mood sy feeling better off de though R58's spous decrease in two mo- increase in delusion patterns. The record documentation of p R58's current care p 6/30/16 identified po- related to depression care plan identified 15 that indicated mo- plan indicated R58 things, had sadness insomnia, was tired had made comment without a plan. The preferred to be in bo- family. R58's care plan ide interventions last da mood alterations as contact medica facilitate appoint mental services as monitor efficace of medications, Will evaluate, m as appropriate/nece	es well when provided No additional issues at this to monitor for potential n & mood and address prn [as d a comprehensive ng the substantial increase in ymptoms and of statements of ad in the last quarter even se had died, there had been a bod altering medications and hal and physical behavior rd further lacked hysician notification. plan provided by the facility on otential for mood alteration on, anxiety, and dementia. The the increase of mood score of oderate depression. The care reported little to no interest in s/frustration, occasional d daily, feels bad about self and ts of being better off dead care plan identified R58 ed when not visiting with ntified and included ated 11/19/14 to manage s: I doctor as needed thment with psych and/or needed by and adverse consequences anges/decline in mood and monitor, intervene or counsel essary.	F 2	50			
		d record lacked evidence the					

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		AND HUMAN SERVICES			FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING		06/:	30/2016
NAME OF I	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	care plan had been mood score from fo During an interview nursing assistant (N out of bed as often bed because she is explained to survey increase in depress made comments th off dead, however v recently passed aw aware of that. NA-D admission liked to b however she did no During an interview licensed practical n not one to come ou admission. LPN-C s her room as much a was not aware R58 feelings she would increase in depress indicated she had n increase in depress aware if or how soc LPN-C explained if symptoms then nur medical record, not members to see if t During an interview activities assistant (from 1:1 visits in he sensory one to one not aware of the rec symptoms and R58 dead. During an interview licensed social work	updated after the change in	F 250			

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		AND HUMAN SERVICES			FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245447	B. WING		06/;	30/2016
NAME OF	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
			1	1200 12TH STREET SOUTHWEST		
SACRED	D HEART CARE CENT	ER	1	AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 250	PHQ-9 score, and s implemented anyth increase in score sl LSW explained the have been situation written a detailed pu plan to include PHQ implemented the in monitor. LSW report things that you can whether they work of had not been updat status and would be the scheduled care the PHQ-9 score co depending on how assessment, however made any follow-up PHQ-9 assessment residents psychoso social services visit were not based on psychotropic medic question, "How do symptoms?" LSW s mood she has a rig have to take the tim find if something is outside referral for been considered or increase in depress statements of being During an interview reported she was n depressive sympton better off dead. During an interview LPN-A reported she	stated, "I don't know that I ing" as a result of the howing worsening depression. increase in symptoms could hal. LSW stated she had rogress note, updated the care Q-9 score changes, and had tervention of continue to rted, "To me interventions are try they are not solutions, or not." LSW stated the family ted of the change in mood e updated today (6/29/16) at conference. LSW explained ould change from day to day R58 was feeling at the time of ver LSW stated she had not o visits since the time of the t on 6/22/16. LSW explained bould explained that visits if the residents received cations. In response to the you manage mood stated, "We don't manage her pht to be angry or sad. You just ne to redirect or reassure and going on." LSW reported, an mental health services had not r addressed following the sion symptoms or the	F 250			

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		AND HUMAN SERVICES				FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING			06/:	30/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
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F 250	During an interview registered nurse (R been made aware of by the social worke reported the chang RN-A explained the record) system ider assessments by se of need for further a RN-A stated a warr a result of the incre 6/22/16, however th the warning, indicat and follow-up was of had been alerted of either by the EHR v communication she comprehensive mo the possible root ca depressive sympton findings as well as of and implement imm explained the proce the resident has de impairments, the m addressed. During an interview director of nursing (the score on the PH addressed and repo- interventions put int have been followed A facility policy pert services was reque Facility policy Medic included necessary and care plan revis	se in depressive symptoms. on 6/29/16, at 12:00 p.m. N)-A indicated she had not of the mood status as reported r. RN-A stated LSW had e this morning (6/29/16) to her. EHR (electronic health ntifies changes on nding out warning messages assessment and intervention. ing message was created as ase in the PHQ-9 score on the social worker had signed ing the alert was addressed completed. RN-A stated, if she if the mood change score varning or verbal e would have completed a od assessment to determine tuse of the increase in ms, notify the physician of the direct care staff, and develop nediate interventions. RN-A tess is the same regardless if mentia and/or memory ood change needs to be f on 6/29/16, at 12:23 p.m. (DON) stated the changes of IQ-9 should have been ported immediately and to place. DON stated, it should	F 2	250			

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTI	PLE CONSTRUCTION). 0938-039 TE SURVEY
-	OF CORRECTION	IDENTIFICATION NUMBER:		3		MPLETED
		245447	B. WING		06	/30/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
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F 250	continued medication address procedures symptoms.	ons. The policy did not s for increases in depressive	F 250	ס		
F 272 SS=D	483.20(b)(1) COMF ASSESSMENTS	PREHENSIVE	F 272	2		7/21/16
	a comprehensive, a	nduct initially and periodically accurate, standardized sment of each resident's				
	resident assessme by the State. The a least the following: Identification and de Customary routine; Cognitive patterns; Communication;	sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information;				
	Continence;	eing; g and structural problems; and health conditions;				
	Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional asses areas triggered by t Data Set (MDS); ar	; summary information regarding ssment performed on the care he completion of the Minimum				

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DEPAR	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
		& MEDICAID SERVICES							
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED			
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912					
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F 272	Continued From pa	ge 9	F 272	2					
	by: Based on observat review, the facilty fa assess missing/bro (R7) reviewed for de Findings include: R7's Admission Red date of 3/26/15. Adm Plan dated 3/26/15. missing teeth." Adm (MDS) dated 4/2/15 Annual MDS dated concerns. On 6/30/16 at 10:04 or four broken and p problems chewing a independent with hi On 6/30/16 at 12:57 (RN)-A, a nurse ma regarding R7's MDS was an error on my plan. Every quarter address if he has an any concerns or wa Facility Assessment dated 1/5/16 reads,	cord indicated an admission mission Care & Assessment oral status revealed "some hission Minimum Data Set i indicated no dental concerns. 3/10/16 indicated no dental 4 a.m. R7 stated he had three missing teeth. R7 denied any and stated he was		It is the practice of Sacred Heart C Center to conduct initially and perio a comprehensive, accurate, standa reproducible assessment of each resident s functional capacity and make a comprehensive assessmer resident s NEEDS using the RAI. As stated, R7 s Admission Assess noted that R7 had some missing te Also, as stated, on 6/30/16, R7 den any problems chewing and stated h independent with dental care, facts supported the indication of no denta concerns on his MDS. As with all residents, R7 is asked at each care conference if he has any dental cor or would like to schedule a dental appointment. R7 has always respon no to these questions. Clinical Managers, who perform assessments and develop care plat have been informed that missing te must be included even if there is no problem or need associated with th Clinical Managers will make a visual inspection of the mouths of all resid on their wings by 7/21/2016 and revi individual assessments and care pl ensure that missing/broken teeth at	dically rdized to to f a ment eth. ied he was that al ncerns nded ns, eth o em. al lents <i>v</i> iew ans to				

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TATEMENT	OF DEFICIENCIES	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		e survey IPleted
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F 272	condition, in order care that will attain practicable physica functioning possibl assessment in turr	age 10 sessment of the resident's to develop consistent quality or maintain the highest al, mental, and psychosocial e. This comprehensive n is used to develop and aprehensive plan of care."	F 27	12 included. CM s will follow this for each new admission and du comprehensive assessments the DON will audit the assessment plans of three new admissions determine if missing or broken on the nursing admission assess also included on the RAI and ca She will report audit results at the QA meeting. A determination w made at that time if additional a needed.	ring nereafter. s and care to teeth noted ssment are are plan. he October vill be	
F 278 SS=D	The assessment m resident's status. A registered nurse each assessment m participation of heat A registered nurse assessment is com Each individual wh assessment must that portion of the a Under Medicare ar willfully and knowin false statement in subject to a civil m \$1,000 for each as willfully and knowin to certify a materia	RDINATION/CERTIFIED nust accurately reflect the must conduct or coordinate with the appropriate alth professionals. must sign and certify that the npleted. o completes a portion of the sign and certify the accuracy of	F 27	8		7/21/16

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		AND HUMAN SERVICES			FORM /	07/27/2016 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
SACRED	HEART CARE CENT	ER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 278	assessment. Clinical disagreeme material and false s This REQUIREMEN by: Based on observat review, the facility f Data Set (MDS) act residents (R18) rev living (ADL). Findings include: R18's quarterly MD identified for toiletin assist. R18's quarter identified R18 requi On 6/29/16, at 7:24 rocking chair in his have a urinary cath right lower extremit	than \$5,000 for each ent does not constitute a	F 27		tants ident, led as limited part ngly. m a cited s tually , it		
	leg bag and was to every two hours. At observed to provide with toileting. NA-A R18's pants and en catheter leg bag. On 6/29/16, at 9:52 stated she was res MDS. RN-A stated emptying a cathete	empty R18's catheter leg bag 9:33 a.m., NA-A was e hands on assistance for R18 assisted pulling down and up nptied urine from R18's c a.m., registered nurse (RN)-A ponsible for coding R18's staff providing the care of r leg bag would be extensive med staff were providing		The facility has recently updated its electronic records capability to allow nursing assistants to chart the assi they are providing at the point of ca This information feeds directly into MDS, allowing less room for error of miscoding. Clinical Managers will continue to accurately complete MI The facility has an excellent record Case Mix Annual Review, with zero changes to levels of care for the pa	w stance are. the or DS's. with		

Facility ID: 00393

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	OF DEFICIENCIES OF CORRECTION	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	0938-039 SURVEY PLETED
		245447	B. WING		06/3	0/2016
NAME OF I	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 278	toileting assist of e	mptying R18's catheter leg bag	F 278	years. The facility will continue to us		
	dated 4/13/16. RN-	nent period for R18's MDS A confirmed R18's MDS dated d as limited assist and should as extensive assist.		review as an indicator of coding acc Results from that review will be pres at the first QA Committee meeting following the review. Based on thos results, the Committee will determin	sented	
	stated staff providin catheter leg bag) w were documenting	7 p.m., the director of nursing ng catheter care (emptying a vas extensive assist and if staff the assist provided erson completing the MDS		Clinical Managers need more educa about completing the MDS or if an in-house monitoring system needs t put in place.		
	would verify the as note for verification	sist provided and document a of accuracy.		The facility policy "Minimum Data Se been reviewed and updated to inclu- "The assessmentwill accurately re the functional capacity of the resider	de: eflect	
F 279 SS=D	6/6/14, was provide address accuracy o 483.20(d), 483.20(Minimum Data Set, dated revised ovided, however the policy failed to acy of coding the MDS. 5.20(k)(1) DEVELOP ISIVE CABE PLANS		the time."		7/21/16
	A facility must use to develop, review comprehensive pla	the results of the assessment and revise the resident's in of care.				
	plan for each resid objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under	t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided 's exercise of rights under				

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STATEMENT OF		& MEDICAID SERVICES				MAPPROVED 0. 0938-0391
AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245447	B. WING	i		5/30/2016
NAME OF PRO	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
SACRED H	EART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Ş. ul	inder §483.10(b)(4)	he right to refuse treatment	F	279		
F O R D R D R D R D R D R D R D R C R C R C	y: Based on observati eview, the facility fa eeth for 1 of 3 resid lental status. Findings include: On 6/27/16, at 3:18 351 had two missin nouth (one on the t bottom gum line). 351's facility Admise 2/3/14, identified ora 351's nursing Asse oral/dental status fa 351's care plan, prin elf-care deficit dress elated to weakness balance, ability varie upervision and ver inxiety, cognitive im leuropathy, catarace egal blindness. Ress as needed dental ap ippointments as ress Resident brushes of On 6/28/16, at 2:56 tated she was resp	ion, interview and record ailed to care plan missing lents (R51) reviewed for p.m., observation revealed g teeth on the left side of his op gum line and one on the sion Assessment, dated al status, some missing teeth. ssment dated 4/27/16, iled to identify missing teeth. Int date 6/29/16, identified asing, bathing, grooming a, impaired sitting, standing es day to day, needs bal cues. Diagnoses of apairment, anemia, it, macular degeneration and sident and family prefer only opointments. Facilitate dental sident/family request. wn teeth after set up. p.m., registered nurse (RN)-A ponsible for completing the nd does visually look in the			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.	d

Facility ID: 00393

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	NO FUN IVIEDICAND	& MEDICAID SERVICES		ĺ	<u>JMB NO.</u>	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	E SURVEY PLETED
		245447	B. WING		06/3	30/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279 F 280 SS=D	completed. RN-A s had missing teeth. Admission Assess confirmed the assess some missing teeth Assessment dated failed to identify mi observed R51's tee side of R51's mout on the top gum line confirmed R51's ca missing teeth. On 6/29/16, at 1:15 stated if missing te assessment and if missing teeth shou The facility Assess System-Care Plan Conference-Interdi indicated Procedur assure that the foll- and/or care planne e. Overall physical 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has th incompetent or oth incapacitated unde participate in plann changes in care ar	tated she was not aware R51 RN-A reviewed R51's facility ment, dated 2/3/14, and essment identified R51 had n and R51's Nursing 4/27/16, oral/dental status ssing teeth. At 3:16 p.m., RN-A eth and confirmed, on the left h, R51 had one missing tooth e and bottom gum line. RN-A are plan failed to include 5 p.m., the director of nursing eth was identified on the an issue with the resident then ld be on the care plan. ment and Care Plan and sciplinary, dated 1/5/16, e 5. The care plan team is to owing areas are addressed d. Completed by the facilitator. status. 10(k)(2) RIGHT TO NNING CARE-REVISE CP the right, unless adjudged erwise found to be in the laws of the State, to ing care and treatment or	F 279	on the nursing admission assess also included on the RAI and care She will report audit results at the QA meeting. A determination will made at that time if additional aud needed.	plan. October be	7/27/16

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	-	AND HUMAN SERVICES & MEDICAID SERVICES		FORM	APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
245447		245447	B. WING	B. WING		06/30/2016		
NAME OF F	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 PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 280	physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	ge 15 red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 2	80				
	by: Based on observat review the facility fa include anxiety sym and ongoing monito behaviors, goals wi for 1 of 5 residents unnecessary medic Findings included: R5's facility admiss of anxiety disorder. R5's quarterly Minin 3/20/16 included dia and demonstrated fi inattention, severe of Brief Interview for M The MDS reported anti-anti-anxiety me look-back period. R5's current printed by the facility on 6/3 0.25 milligram (mg) for anxiety up to da (shortness of breatt date of 3/23/16. The				Diagnosis of anxiety with monitorin facility policy was added to R5's Ca on 6/28/2016, during the survey. Clarification was received from the physician that Alprazolam is given for dyspnea. Clinical Managers will continue to re all Care Plans at least quarterly and revisions as needed. Consulting Pharmacist will continue to do routin med reviews for all residents. Risk Management Committee will contin review psychotropic medications for residents monthly and as needed. In conjunction with each care plan r and care conference during the mo August and September, each Clinic Manager will note if the resident(s) are reviewing is currently taking a psychotropic medication and if so, werify that the Care Plan accurately reflects an appropriate diagnosis ar behavioral symptoms and manager	re Plan or eview d make ne ue to r all review nths of cal they will		

Facility ID: 00393

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PRINTED: 07/27/2016

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-033 (X3) DATE SURVEY COMPLETED 06/30/2016									
							NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
							SACRED	HEART CARE CENT	TER			200 12TH STREET SOUTHWEST USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETI DATE							
F 280	Continued From pa		F 28	80	for that registers. They will report th									
	5/11/16. Physician' Buspirone 15 mg tr start date of 3/31/1 R5's Medication Ac and June 2016 refl Alprazolam 0.25 m twice-daily adminis R5's current care p 6/30/16 did not ide lacked a plan of ca monitoring and inter management. The identification of mo prescribed anti-any During observation was resting in her I During an observat and at 1:26 p.m. R	dministration Record for May ected nightly administration of ig (nightly after 5/11/16) and stration of Buspirone 15 mg. blan provided by the facility on ntify diagnosis of anxiety and ure for anxiety target behavior erventions for symptom care plan also lacked initoring and management of kiety medications. is on 6/27/16, at 3:27 p.m. R5 bed with her eyes closed. tions on 6/28/16 at 8:42 a.m. 5 was sitting quietly in her			for that resident. They will report the results of these audits at the Octob Committee meeting. The QA Con will determine at that time if there is need for additional audits.	oer QA nmittee								
	director of nursing plan and indicated for anxiety and stat stated R5's care pl Facility policy Medi reviewed 2/7/16 ind	v on 6/28/16, at 2:20 p.m. (DON) reviewed R5's care there was not a plan of care ted there should be one. DON an would be updated today. cation Management Policy last cluded, "Information gathered												
	incorporated into a reflects appropriate parameters for mo and ongoing need but not limited to, w responsible fro mo	d ongoing evaluations are comprehensive care plan that e medication-related goals and nitoring the resident's condition for medication(s), including, vhat is monitored, who will be nitoring, and how often and												
	Procedure included sole approach for b	on is necessary." hotropic Medication Policy and d, "Medications use is not the pehavioral intervention. Other e identified in the care plan."												

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		AND HUMAN SERVICES & MEDICAID SERVICES				APPROVEI 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245447	B. WING		06/3	30/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI			
SACRE	HEART CARE CENT	ER		1200 12TH STREET SOUTHWES AUSTIN, MN 55912	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 281 SS=D	483.20(k)(3)(i) SER PROFESSIONAL S	VICES PROVIDED MEET TANDARDS	F 2	81		7/29/16	
		ed or arranged by the facility onal standards of quality.					
	by: Based on observat review, the facility fa grooming as directe of 1 resident (R70) living. Findings include: R70 had been obse and 6/28/16, at 1:47 black facial hair on R70 admitted to the diagnoses of deme and optic atrophy, a admission record. R70's Admission As dated 6/8/16 inform glasses for both dis indicated R70 repor related to macular of informed R70 had a limitations and had During an interview licensed practical n residents do not ha family to bring one i the facility had a co available if the resic During an interview stated R70's bath d	NT is not met as evidenced ion, interview and record ailed to complete facial ed in the initial care plan for 1 reviewed for activities of daily erved on 6/27/16, at 2:53 p.m. 7 p.m. R70 had long grey and the left side of her chin. e facility on 6/8/16 with ntia, macular degeneration, according to the facility esessment and Care Plan ed staff resident needed tance and reading and ted vision is worse at times degeneration. The assessment activities of daily living a self care deficit. on 6/28/16, at 1:32 p.m. urse (LPN)-B indicated if ve their own razors we contact n for them. LPN-B reported mmunity razor that was lent did not have one. on 6/28/16, at 1:39 p.m. NA-B ays were on Sundays and NA-B stated R70 was		R70 was described as in cares. NA-C immediately hair from R70 s chin why known to her that the resi removed. However, NA-C process as using a tweez three hairs from the resid of which exceeded one-fo length not really consis deficiency description as black facial hair. A razor for R70. Nursing Assistant be held during the week of nursing assistants will be the need to monitor facial resident is otherwise inde The QA Coordinator, or h audit facial grooming for a resident on each wing we weeks (does not have to residents each week). If not meet a professional s responsible nursing assis directed to offer additional resident, including remov QA Coordinator will repor at the first QA meeting fol completion of the audits. continued audits will be d meeting.	v removed the en it was made ident wanted it C described the errs to remove ent s chin, none purth inch in tent with the long grey and was purchased at meetings will of July 25-29 and reeducated on I hair, even if the pendent. er designee, will at least one tal least one tandard, the stant will be I grooming to the al of chin hairs. t results of audits lowing the Need for		

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING		06/:	30/2016
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 281	when she needs he up her wash clother NA-B explained if re families need to brin or two strands then stated if residents of then we notify the m NA-B went on to ex or they do not bring notify social service in their account to g there was not mone be documented in t was not shaved. NA have a community control purposes ar contamination betw During an observat at 1:52 p.m. NA-C i is removed everyda R70 back to her roo NA-C reported the I removed if R70 was asked R70 if she ha husband usually ret tweezers. R70 state facial hair because the facial hair to be remove it. NA-C the During an interview director of nursing (not have a commun purposes and we re provide the razors. did not bring one in	dent and puts on her light dent and puts on her light dp. NA-B stated she would set is in her bathroom sink for her. esidents have facial hair, ng in razors or if they have one we just pluck them out. NA-B lid not have their own razors urse and they call the family. plain if the family is not around a razor in then we would is to see if there is any money get one. NA-B stated then if ey in the account then it should he record why the resident A-B reported the facility did not razor because of infection ad possibility of cross	F 281			

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION	OMB NO.	E SURVEY	
-	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				IPLETED	
		245447	B. WING _		06/	30/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 281	staff should follow t	be included in the care plan, he care plan, and if the aved the reason should be	F 28	31			
F 282 SS=D	PERSONS/PER CA The services provid must be provided b	RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of	F 28	32		7/29/16	
	by: Based on observat review, the facility fa grooming as care p observed for activiti Findings include: R5 had been obserr and 6/28/16, at 8:42 black/grey facial ha R5's quarterly Minin 3/30/16 indicated se with a Brief Intervier score of 4 and exte staff members for p R5's care plan inclu in areas of dressing related to mild cogn plan directed, "staff	ved on 6/27/16, at 3:27 p.m. 2 a.m. R5 had long thin ir on her chin and upper lip. num Data Set (MDS) dated evere cognitive impairment w for Mental Status (BIMS) nsive physical assist from two personal hygiene. Ided R5 had a self-care deficit g, bathing, and grooming hitive impairment. The care		As stated by LPN-B, facility had contacted R5 s son multiple tim request a razor for the purpose of removing facial hair from residen (Facility does not have a razor for multiple residents.) Son had stat had always had facial hair and it bother her. He did, however, brin to the facility on 6/30/2016 and it used as needed. Previously, he sometimes bring a razor with him visit and would shave his mother He did not, however, leave the ra- the facility for daily use. Nursing Assistant meetings will b during the week of July 25-29 an assistants will be reeducated on to take if a resident does not hav for facial grooming. Applicable fa policies have been updated to im recognition of shaving preference procedures.	f t. r use on red R5 didn t ng a razor is being would n during a himself. izor at e held d nursing the steps e a razor acility clude		

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		AND HUMAN SERVICES	-			FORM	07/27/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245447	B. WING		·····	06/3	30/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST JUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	days were Thursda could wash her fact take care of nails a residents should be day. NA-C stated it shaved in a while a explained the facilit bring in a razor. NA facility had a comm During an interview licensed practical m residents do not ha family to bring one the facility had a co available if the resid reported multiple at family to bring in we During an interview director of nursing not have a commun purposes and we re provide the razors. did not bring one in resident account. D preferences should staff should follow t resident was not sh documented in the Facility policy Activi Functions) last revi "The purpose of ac provide assistance functions. To super to maintain optimur	NA)-C reported R5's shower y evenings, and indicated R5 e, and arms. NA-C stated "We nd facial hair." NA-C stated e checked for facial hair every looked like R5 had not been nd needed to be done. NA-C ty has attempted for family to A-C reported she thought the nunity razor. on 6/28/16, at 1:32 p.m. urse (LPN)-B indicated if the their own razors we contact in for them. LPN-B reported ommunity razor that was dent did not have one. LPN-B ttempts had been made for orking razors. on 6/29/16, at 12:45 p.m. (DON) stated, the facility does nity razor for infection control equest family members DON explained if the family then facility would check the DON explained shaving I be included in the care plan, the care plan, and if the naved the reason should be	F2	282	The QA Coordinator, or her design audit personal grooming for at leas resident on each wing weekly for for weeks (does not have to be the sa residents each week). If adequate grooming has not been completed, responsible nursing assistant will b directed to offer additional groomin resident, including removal of chin The QA Coordinator will review the plan and notify the Clinical Manage shaving preference was not include the care plan. QA Coordinator will results of audits at the first QA mee following the completion of the aud The need for continued audits will b determined at that meeting.	t one our me the e g to the hairs. care er if ed on report eting its.	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		. 0938-039 E SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		ING		IPLETED		
		245447	B. WING			06/30/2016		
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1200 12TH STREET SOUTHWEST				
ACRED	HEART CARE CENT	ER		AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE		
F 282	life function. The por requirements for en procedures."	blicy did not include Insuring shaving preferences or	F 2	82				
F 312 SS=D			F 3	12		7/29/16		
	by: Based on observat review the facility fa assistants for a dep the care plan for 1 of activities of daily live Findings included: R5 had been obser and 6/28/16, at 8:42 black/grey facial ha R5's quarterly Minin 3/30/16 indicated so with a Brief Intervie	ved on 6/27/16, at 3:27 p.m. 2 a.m. R5 had long thin ir on her chin and upper lip. num Data Set (MDS) dated evere cognitive impairment w for Mental Status (BIMS) nsive physical assist from two		As stated by NA-C, facilit R5 s son multiple times to razor for the purpose of re- hair from resident. (Facilit a razor for use on multiple Son had stated R5 had al- hair and it didn t bother h- however, bring a razor to 6/30/2016 and it is being to At meetings on 7/20/2016 reeducated on procedures resident is in need of a raz reminded that there is no "community razor." They informed to contact the CI or DON if families do not requests for a razor. Appli	o request a emoving facial y does not have e residents.) ways had facial her. He did, the facility on used as needed. I, nurses were s to take if a zor and were such thing as a were also linical Manager respond to			

Facility ID: 00393

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		AND HUMAN SERVICES				FORM	07/27/201 APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	· · /	E SURVEY PLETED
		245447	B. WING _			06/3	30/2016
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE 12TH STREET SOUTHWEST		
SACREE	HEART CARE CENT	ËR					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 312	R5's care plan incluin areas of dressing related to mild cogriplan directed, "staff During an interview nursing assistant (N days were Thursda could wash her fact breasts. NA-C staff facial hair." NA-C staff facial hair. " NA-C staff facial hair." NA-C staff facial hair. " NA-C staff facial hair." NA-C staff facial hair." NA-C staff facial hair. " NA-C staff facial hair." NA-C reported she community razor. During an interview director of nursing in the provide the razors. did not bring one in resident account. Direferences should staff should follow the resident was not she documented in the Facility policy Activi Functions) last revi "The purpose of ac provide assistance functions. To super to maintain optimur possible, and to relife function. The purpose of ac provide facing function. The purpose of ac provide facing function. The purpose of ac provide for the purpose of ac provide assistance functions. To super to maintain optimur possible, and to relife function. The purpose of ac provide facing function. The purpose of ac provide for the purpose of ac provide assistance functions. To super to maintain optimur possible, and to relife function. The purpose of ac provide for the purpose of ac provide for the purpose of ac provide for the purpose of ac provide assistance functions. To super to maintain optimur possible, and to relife function. The purpose of ac purpose of ac provide for the purpose of ac provide for the purpose of ac provide for the purpose of ac provide assistance functions. To super to maintain optimur possible, and to relife function.	Juded R5 had a self-care deficit g, bathing, and grooming hitive impairment. The care f shave resident." on 6/28/16, at 1:26 p.m. NA)-C reported R5's shower by evenings, and indicated R5 e, arms and underneath her ed "we take care of nails and stated residents should be hair every day. NA-C stated it not been shaved in a while done. NA-C explained the ed for family to bring in a razor. thought the facility had a on 6/29/16, at 12:45 p.m. (DON) stated, the facility does nity razor for infection control equest family members DON explained if the family then facility would check the DON explained shaving I be included in the care plan, the care plan, and if the naved the reason should be record. ties of Daily Living (Daily Life ewed on 1/5/16 included, tivities of daily living is to to resident for daily life vise resident activities in order m functions as long as reducate in techniques of daily	F 31	pc re pr Nu du as gr gr is Th au ea (d ea gr ca nu fac co pla au co co	blicies have been updated to inclu- ecognition of shaving preferences rocedures. ursing Assistant meetings will be uring the week of July 25-29 and ssistants will be reeducated on the rooming practices, the steps to take solution does not have a razor for rooming, and will be reminded that no such thing as a "community re- he QA Coordinator, or her design udit the care plan and personal opearance of at least one resider ach wing weekly for the next four loes not have to be the same res- ach week) to determine if facial rooming is being completed as are-planned. If not, the responsitu- ursing assistant will be directed to cial grooming to the resident. The oordinator will review the care pla- ptify the Clinical Manager if shavi- reference was not included on the an. QA Coordinator will report re- udits at the first QA meeting follow ompletion of the audits. The nee- pontinued audits will be determined eeting.	held nursing orough ke if a facial at there azor." hee, will nt from weeks idents ble o offer he QA an and ng e care esults of wing the d for	

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	1				. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	TRUCTION		E SURVEY
		245447	B. WING			06/	30/2016
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER			I, MN 55912		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI	-	(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
F 312	Continued From pa	ao 23	F 3	10			
1 012	procedures."	ge 25	гэ	12			
	procedures.						
		(Morning) Care, HS (bedtime)					
	Cares, and Hair Ca	re did not include isuring shaving preferences or					
	procedures.						
F 329		EGIMEN IS FREE FROM	F 3	29			7/19/16
SS=D	UNNECESSARY D	RUGS					
	Each resident's dru	g regimen must be free from					
		An unnecessary drug is any					
		excessive dose (including or for excessive duration; or					
		ionitoring; or without adequate					
		se; or in the presence of					
		nces which indicate the dose or discontinued; or any					
	combinations of the						
	Deced on a compre	banaiva appagament of a					
		hensive assessment of a must ensure that residents					
	who have not used	antipsychotic drugs are not					
		Inless antipsychotic drug					
		ry to treat a specific condition locumented in the clinical					
		ts who use antipsychotic					
		ual dose reductions, and					
		tions, unless clinically an effort to discontinue these					
	drugs.	an enore to discontinue triese					
		JT is not mat as sublement					
	by:	NT is not met as evidenced					
		ion, interview and record		R57	's target behavior of making	suicidal	

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TATEMEN	F OF DEFICIENCIES OF CORRECTION	KI PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY PLETED		
		245447	B. WING _		06/:	30/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	00/2010		
SACRE	HEART CARE CENT	ſER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE		
F 329	review, the facility is behaviors to detern antianxiety and and 5 residents (R57) medications. Findings include: R57's admission re- indicated that the most- post-traumatic stree disorder, mild cogr disorder, depender generalized anxiety R57's physician or that the resident has Risperidone (an ar (milligrams) to be the related to major de R57 had been press antianxiety medicat to take 0.5 mg by m to generalized anxi R57's quarterly Min 2/24/16, indicated for cognitively intact. R57's psychoactive dated 5/24/16, indi- taking 0.5 mg of At addition to Risperd stated that she suf and generalized ar behaviors consister and anxiety, crying it stated that R57 fr	failed to identify specific target mine efficacy for the use of an tipsychotic medications for 1 of eviewed for unnecessary ecord, dated, 9/25/2014, esident had diagnoses of ess disorder, major depressive nitive impairment, panic nt personality disorder and y disorder. ders, dated, 8/27/15 indicated ad been prescribed ntipsychotic medication) 2 mg aken by mouth at bedtime epressive disorder. In addition, scribed Lorazepam (an tion), dated 11/13/15. She was nouth three times a day related	F 32	comments was being monitored and Risk Management Committ Communication to nursing assis target behavior for R57 and documentation by nurses has be improved by adding target beha R57 to the electronic Point of Ca (completed every shift by NA s electronic Medication Administra Record (completed every shift b) On 7/12/16, target behavior for changed to hallucinations. The Psychotropic Medication Policy reviewed and updated by severa members of the Risk Managem Committee. The Risk Managem Committee will continue to moni behaviors, gradual dose reduction psychotropic medication use for residents at least monthly. These been reviewed for all residents the appropriate identification of target behaviors Clinical Manager RN-B will mon documentation of target behavior until the next Quality Assurance Committee as to the continue of reading. Results with reported and a determination with by the committee as to the continue need for audits.	ee. itants of een vior for are) and the ation y nurses). R57 was was al ent tor target ors, and all se have o ensure et itor ors weekly II be II be II be made			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245447	B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	monitor the efficacy that R57 was readin 8/27/15 with new or not have any suicid recommended to co R57's medication a reviewed from 6/1/1 that the resident ha Risperdal as prescr R57's care plan, da resident had a pote to diagnoses of any dependent persona lengthy psychologic stays in a behaviora history of electrocol suicidal ideation. R5 health which R57 re a history of tongue thrusting the lower the staff to monitor in her mood and ad care plan also reco psychological medif facility policy. It adv hallucinations, delu she had a plan to c R57's doctor's prog stated that the resid psychiatrically which psychopharmathera that something mus polypharmacy.	mmended to continue to of the medications. It stated nitted back to the facility on oders for Risperdal. R57 did al comments this month. It ontinue to same plan of care. dministration record (MAR), 13 through 6/30/16, indicated d been taking the Ativan and ibed. ted 10/3/2014, stated that the ntial for altered mood related ciety, depression, panic and lity disorder. R57 had a cal history with prior hospital al healthcare unit and had a nvulsive treatment along with 57 was followed by mental eported as beneficial. R57 had thrusting and sucking and lip. The care plan encouraged R57 for changes and declines idress them as needed. The mmended to monitor her cation as directed by the ised to question R57 about sions, wanting to die and if	F 32			

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CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	F OMI	=ORM / <u>B NO.</u> (3) DATE	07/27/2016 APPROVED 0938-0391 SURVEY PLETED
		245447	B. WING _			06/3	30/2016
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COL)E		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BI		(X5) COMPLETION DATE
F 329	exhibited when she that when she was herself from human When interviewed of nursing assistant (N behaviors and moo instructed to notify f document. NA-F sta angry if someone w stated that R57 did roommate and wou been resolved. Whe isolate herself, NA- tendency to isolate she saw R57 isolate week. When asked NA-F stated no but when R57 had gond seeing things and ta When interviewed of NA-G was asked w been instructed to r to document. NA-G any behaviors that a stated that she did R57 did not exhibit tended to isolate her isolated herself. Wh hallucinations or de well. When interviewed of NA-H stated that sh any behaviors such or delusions. NA-H	pes of behaviors she became anxious. She stated anxious she tended to isolate a company. on 6/29/16 at 1:32 p.m. NA)-F was asked what target d symptoms she had been the nurses in order to ated that R57 would get very vere to call her a man. NA-F not get along with a previous Id say things but that had en asked if R57 did tend to F stated that R57 did have a herself a lot. NA-F stated that e herself once or twice a if R57 had any hallucinations, stated a couple months ago e to the hospital she was	F 32	229			

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	-	AND HUMAN SERVICES			FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245447	B. WING		06/:	30/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	thoughts of killing h seemed calm and c When interviewed c registered nurse (R psychiatrist had pre- the Risperdal. R57' not prescribe these asked what specific staff had been mon- two medications we stated R57 had been suicidal comments. started on Risperda she had been in the the Ativan had not k just prescribed. RN on the medication p When asked what r anxiety R57 had ex would make freque which was due to h When interviewed c stated that R57 had stated that R57 had estated that R57 had stated that	erself. NA-H stated that R57 did not tend to isolate herself. on 6/30/16 at 10:35 a.m., N)-B stated that R57's escribed both the Ativan and s primary care physician did medications. RN-B was c target behaviors the nursing itoring for to determine if the ere affective or not. RN-B en monitored for making RN-B stated that R57 had al back in August 2015 when e hospital. RN-B stated that been something that R57 was -B stated that R57 had been prior to coming to the facility. resident centered behaviors of hibited RN-B stated that R57 nt repetitive health complaints er anxiety. on 6/30/16 at 12:30 p.m., RN- d never exhibited psychotic d when R57 had been placed ame back to the facility, the m (IDT) had reviewed her red at the time the only thing ited was that one time R57 al comment and so the nursing	F 329			

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		AND HUMAN SERVICES				FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	E SURVEY PLETED
		245447	B. WING			06/;	30/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329 F 334 SS=E	Procedure, last revi that each resident's from unnecessary r unnecessary drugs without adequate m medication was init resident was monito effectiveness of the to be documented of sheet.	ige 28 hotropic Medication Policy and iewed on 2/6/2014, it stated a drug regimen must be free medications. It identified as any medication used nonitoring. When antipsychotic iated, it stated that the ored to determine the medication. Behaviors were on the behavior documenting NZA AND PNEUMOCOCCAL		329			7/21/16
33=L	The facility must de that ensure that (i) Before offering th each resident, or th representative rece benefits and potent immunization; (ii) Each resident is immunization Octob annually, unless the contraindicated or t immunized during t (iii) The resident or representative has immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po immunization; and (B) That the reside	offered an influenza offered an influenza oer 1 through March 31 or immunization is medically he resident has already been his time period;					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD)ING	3	COlvi	PLETED
		245447	B. WING			06/3	30/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST		
SACRE	D HEART CARE CENT	ER			AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	influenza immuniza contraindications or The facility must de that ensure that (i) Before offering th immunization, each legal representative the benefits and por immunization; (ii) Each resident is immunization, unless medically contraind already been immuni (iii) The resident or representative has immunization; and (iv) The resident's re documentation that following: (A) That the resider representative was the benefits and por pneumococcal imm (B) That the resider pneumococcal imm the pneumococcal imm the pneumococcal imm the pneumococcal imm years following the immunization, unless	ation due to medical r refusal. evelop policies and procedures he pneumococcal n resident, or the resident's e receives education regarding otential side effects of the s offered a pneumococcal ss the immunization is dicated or the resident has inized; the resident's legal the opportunity to refuse medical record includes t indicated, at a minimum, the ent or resident's legal provided education regarding otential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative		334			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	07/27/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION ()		E SURVEY PLETED
		245447	B. WING	à		06/3	80/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 334	Continued From pa	ge 30	F	334			
	by: Based on interview facility failed to ensu R12, R38, R4 and F received the 13-val- vaccine (PCV13) va by Centers for Dise Findings include: R43's Admission R4 indicated that the re Alzheimer's disease R43's Immunization (11/27/2001), indica received the 23-val- polysaccharide vac PCV13. R12's Admission R4 indicated that the re Alzheimer's disease pulmonary disease R12's Immunization indicated that the re 23-valent pneumoc (PPSV23) but not th R38's Admission R4 indicated that the re cognitive impairment R38's Immunization	ecord, dated 1/6/2015, esident had a diagnosis of e. In Report, dated historically ated that the resident had ent pneumococcal cine (PPSV23) but not the ecord, dated 5/3/2010, esident had diagnoses of e and chronic obstructive (COPD). In Report, dated 5/7/2011, esident had received the occal polysaccharide vaccine he PCV13. ecord, dated 3/2/2012, esident had a diagnosis of mild nt.			As noted, all identified residents had received the 23-valent pneumococca polysaccharide vaccine and there ha been initial discussion of the need to the PCV13 vaccine. R43, R12, R38, and R35 (or responsible parties) hav now received information about the 13-valent pneumococcal conjugate vaccine and have completed a writte form indicating their preference in re- to receiving the PCV13 vaccine. If th preference is to receive PCV13, that information will be passed on to their primary physician, who will be respon- for determining the timing of the vaccination according to CDC recommendations and for giving the for the vaccination. The immunization records of all reside will be reviewed in conjunction with th next scheduled physician visit. Information about PCV13, if the reside has not yet received it, will be given to responsible parties by the Rounds N when she gives notification to them of date of the next scheduled physician The form indicating acceptance or declination of PCV13 must be compli- before the physician can address it. The Director of Nursing will compile a of existing residents who have not received the PCV13 vaccine and give information to the Rounds Nurse for further action as described above. N	al d offer , R4, re en gard neir r nsible order dents heir dent to urse of the visit. leted a list e the	

Facility ID: 00393

		AND HUMAN SERVICES			FOF	D: 07/27/2016 M APPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245447	B. WING			6/30/2016
NAME OF F	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	
SACRED	HEART CARE CENT	ER		-	200 12TH STREET SOUTHWEST AUSTIN, MN 55912	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOULD BE		
F 334	Continued From pa	age 31	F 3	34		
	•	cine (PPSV23) but not the		0.	residents will receive this information at admission. The DON or Infection Controllist will report the number of residents as	
		cord, dated 10/26/2015, esident had diagnoses of iomyophathy.			well as how many are accepting or declining PCV13 at, at least, the next two quarterly Infection Control/Safety meetings. The need for continued	
	(4/1/2002), indicate received the 23-val polysaccharide vac	Report, dated historically ed that the resident had ent pneumococcal ccine (PPSV23). R4 received a n 12/15/2009 but not the			reporting will be determined at the secor meeting.	ıd
	indicated that the re	ecord, dated 11/11/2014, esident had diagnoses of: ure and chronic kidney				
	(11/1/2011), indicat received the 23-val	n Report, dated historically ed that the resident had ent pneumococcal ccine (PPSV23) but not the				
	director of nursing s about the new requivaccine to resident had not yet begun to Medical Director has stated that they hav it yet but it was goin	on 6/30/16 at 2:37 p.m., the stated that she started hearing irrements to offer the PCV13 s last year. She stated that she to push the policy yet but the ad begun talking about it. She yen't begun instituting offering ng to be in the works. N CONTROL, PREVENT	F 4	41		7/21/16
		stablish and maintain an rogram designed to provide a				

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		AND HUMAN SERVICES				FORM	APPROVED
	<u>SFOR MEDICARE</u> OF DEFICIENCIES						0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245447	B. WING			06/3	30/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER					
				4	AUSTIN, MN 55912		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
					/		
F 441	Continued From pa	ae 32	F 4	41			
	=	comfortable environment and		•••			
	to help prevent the	development and transmission					
	of disease and infe	ction.					
	(a) Infection Contro	l Program					
	The facility must es	tablish an Infection Control					
	Program under whi						
	in the facility;	ntrols, and prevents infections					
		rocedures, such as isolation,					
		o an individual resident; and					
	(3) Maintains a reco	ord of incidents and corrective					
	(b) Preventing Spre						
		tion Control Program esident needs isolation to					
		of infection, the facility must					
	isolate the resident.						
		t prohibit employees with a ease or infected skin lesions					
		with residents or their food, if					
	direct contact will tr	ansmit the disease.					
		t require staff to wash their					
	hand washing is inc	rect resident contact for which					
	professional practic						
	/ \ . .						
	(c) Linens	ndle, store, process and					
		as to prevent the spread of					
	infection.						
		NT is not met as evidenced					
	by: Record on interview	and report review the feetling			Equility would like to note that as the	litio io	
		v and record review, the facility rend ongoing infections to			Facility would like to note that cellu a non-contagious condition and pos		

Facility ID: 00393

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		& MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
		245447	B. WING _		06/3	30/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 441	Continued From pa	age 33	F 44	11		
	prevent infections.	ducation was necessary to This included review of R35 on recorded on the April 2016		potential threat to other resident visitors.	s, staff, or	
	infection log. This h residents, staff and Findings include:	nad the potential to effect all visitors.		Facility uses colored coded map to assist in tracking infections a identifying if clusters of infection Supervisory staff are given more	nd is exist. ning report	
	with diagnosis of C included antibiotic of	on the April 2016 infection log ellulitis. Documentation of Bactrim DS give one for ten		daily including information relate number, types and locations of present in the facility, whether o resident is receiving an antibioti	nfections r not the c. Based	
	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	n found on log. No indication if tive and if cellulitis had no indication if education of		on this information a determinat be made to increase hand washing audits, to provide addit education to staff, or to contact	ional Medical	
	Review of the facilit	e to lack of trending. ty's Monthly Infection Report		Director regarding possible nee quarantine. Nurses complete in notes in the progress notes whe	fection n a	
	contained a total ar	s for April, May and June 2016 mount of infections for each vere color coded on a map of		resident is receiving an antibioti facility has multiple policies in p related to infection control, such	ace	
	the facility which ide infection was locate	entified which wing each ed. An order listing report for ily indicated residents who had		hand-washing, universal precau procedures for cleaning and dis equipment, etc. The Infection C	tions, infecting	
	received antibiotics antibiotics, and star antibiotics. The infe	a, indication for use of rt and stop dates of the ection control logs lacked all an infection that was not		nurse also does observations of assistants performing cares to r infection control procedures.	nursing	
	of infection trends a facility acquired infe	biotic, an overall assessment and lacked identification of ections. In addition, the logs mentation of preventative		In addition to continuing these p the DON will maintain an infecti- tracking all infections and docur the assessment of trends or the	on log, nenting	
	measures to stop o	or reduce the risk for spread of occurred in the facility during		The Administrator will review the		
	When interviewed of infection control nu	on 6/30/2016 at 2:08 p.m., the rse, (LPN)-A stated that hitored when they were placed		before the next quarterly Infection meeting and will discuss with th what changes, if any, might be r	on Control e DON	

Facility ID: 00393

If continuation sheet Page 34 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ()		E SURVEY PLETED
		245447	B. WING			06/3	30/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441 F 520 SS=C	have resolved when of medication. She writing in an infection was resolved or not A copy was request	stated that the infection should in they were given the last dose stated that the staff should be on note whether the infection and trending infections. BERS/MEET	F 4		The DON will report on the progress any problems or challenges with the the next Infection Control meeting ar next quarterly Quality Assurance me	log at nd the	7/19/16
	assurance committ nursing services; a facility; and at least facility's staff.	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the					
	committee meets a issues with respect and assurance acti develops and imple	nent and assurance t least quarterly to identify to which quality assessment vities are necessary; and ments appropriate plans of entified quality deficiencies.					
	disclosure of the re except insofar as s	retary may not require cords of such committee uch disclosure is related to the committee with the s section.					
		by the committee to identify deficiencies will not be used as s.					
		NT is not met as evidenced					
							-

If continuation sheet Page 35 of 36

		AND HUMAN SERVICES				FORM	07/27/201 APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245447	B. WING			06/:	30/2016	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SACRED	HEART CARE CENT	ER		1200 12TH STREET SOUTHWEST AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 520	Continued From pa	age 35	F 5	520				
	facility failed to ens designated physicia assessment and as of 4 quarterly QAA Findings include: Review of the facilit records, reviewed f revealed the medic meeting held on 7/1 4/11/16 (a period of attendance records attended the QAA r 11/9/15 and 1/18/16 On 6/30/16, at 2:07 coordinator (QAC)- director had not attr required quarterly. tried to coordinate f medical director wa he can be present. physician was pres director. The QAC Medical Director wa The facility policy, u	ty's QAA meeting attendance from 7/13/15 to 4/11/16, cal director attended the QAA 13/15 and not again until f nine months). The s revealed no physician meetings held on 9/28/15,			It has proven difficult at times for the Medical Director to attend all QA medical Director to attend all QA medical Director to see residents and accomplish other tasks is limited. However, he reads the Minutes from meeting he was not able to attend a easily contacted for input about any quality issues. After the survey, the Coordinator contacted the Medical Director to develop a plan to improv- attendance at QA meetings. This is more communication regarding his scheduled time in Austin and the possibility of his attending through a if necessary.	eetings m any and is / @ QA / e his nvolves		

If continuation sheet Page 36 of 36

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	T5447024	(X3) DAT	. 0938-0391 E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	Ą, BUILD	ING 01 - MAIN BUILDING 01	CON	IPLETED
		245447	B, WING		06/	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST		
SACRED	HEART CARE CENT	ER		AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K	000		
	FIRE SAFETY					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Divisio Sacred Heart Care substantial complia participation in Meo Subpart 483.70(a), 2000 edition of Nat Association (NFPA Code (LSC), Chapt PLEASE RETURN	R THE FIRE SAFETY spections Division Suite 145	à.	EPOC		
LABORATOR' Electror		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 07/21/2010

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.

		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245447	B. WING			06/	29/2016
NAME OF F	ROVIDER OR SUPPLIER			_	TREET ADDRESS, CITY, STATE, ZIP CODE	1 001	
SACRED	HEART CARE CENT	ER			200 12TH STREET SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa By email to: Marian.Whitney@s Angela.Kappenmar	tate.mn.us and	K	000	2		
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pre	oposed, completion date.			-		
		r title of the person rection and monitoring to ence of the deficiency.					
	buildings. Sacred I building with a parti constructed at 2 dif building was constr determined to be of 1997, addition was that was determine construction. Becau the 1 addition are of construction and m	eet the construction type buildings, the facility was					
	fire alarm system w detection and space	r sprinklered. The facility has a vith full corridor smoke es open to the corridors that is matic fire department					
		apacity of 59 beds and had a time of the survey.					

Facility ID: 00393

	OF DEFICIENCIES	E & MEDICAID SERVICES			T	0938-039 E SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION 01 - MAIN BUILDING 01		IPLETED	
		245447	B, WING		06/	29/2016	
NAME OF	PROVIDER OR SUPPLIER		รา	TREET ADDRESS, CITY, STATE, ZIP CODE	7.		
SACRED	HEART CARE CENT	ER		200 12TH STREET SOUTHWEST USTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE	
K 000	Continued From pa	age 2	K 000				
	The requirement at NOT MET as evide	t 42 CFR, Subpart 483.70(a) is					
K 018 SS=D		FETY CODE STANDARD	K 018			7/6/16	
	required enclosure hazardous areas si as those constructe core wood, or capa 20 minutes. Cleara and floor covering i in fully sprinklered required to resist th no impediment to ti open devices that r pushed or pulled at provided with a me door closed. Dutch permitted. Door fra made of steel or ot with 8.2.3.2.1. Rolle CMS regulations in 19.3.6.3	brridor openings in other than s of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ince between bottom of door is not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is he closing of the doors. Hold release when the door is re permitted. Doors shall be ans suitable for keeping the doors meeting 19.3.6.3.6 are mes shall be labeled and her materials in compliance er latches are prohibited by all health care facilities.		€ 8			
	required enclosure: hazardous areas sl as those constructs core wood, or capa 20 minutes. Cleara and floor covering i in fully sprinklered required to resist th no impediment to the open devices that response	corridor openings in other than s of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least nce between bottom of door is not exceeding 1 inch. Doors smoke compartments are only he passage of smoke. There is he closing of the doors. Hold release when the door is re permitted. Doors shall be		The noted basement door has bee planed to ensure positional latching capability.		2	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 07/22/2016 APPROVED : 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245447	B. WING		06/	29/2016	
	PROVIDER OR SUPPLIER	ÉR					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
K 018	permitted. Door framade of steel or oth with 8.2.3.2.1. Rolle CMS regulations in 19.3.6.3 Findings include: On facility tour betw 06/29/2016, observ following was found 1.Basement hallwa positional when tes These deficient pra	doors meeting 19.3.6.3.6 are mes shall be labeled and her materials in compliance er latches are prohibited by all health care facilities. veen 11:00am and 2:00pm on ration revealed, that the the d: y door does not latch	κo				
FORM CMS-25	567(02-99) Previous Versions	s Obsolete Event ID: LKO9:	21	Facility ID: 00393	If continuation sh	eet Page 4 of	

		AND HUMAN SERVICES & MEDICAID SERVICES		4	F5447024	FORM): 07/22/2016 / APPROVED). 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		E CONSTRUCTION 12 - 2007 ADDITION		TE SURVEY MPLETED	
		245447	B. WING	i		06	/29/2016	
	ROVIDER OR SUPPLIER	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 12TH STREET SOUTHWEST AUSTIN, MN 55912					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 000	by the Minnesota D State Fire Marshall survey, (Sacred He substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA) Code (LSC), Chapt This facility will be s buildings. Sacred H addition was constr be of Type II (111) of The building is fully fire alarm system w detection and space monitored for autom notification.	Initial Survey was conducted epartment of Public Safety - Division. At the time of this art Care Center) was found in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 18 New Health Care. Surveyed as two separate leart Care Center, In 2007, an ucted that was determined to construction. sprinklered. The facility has a rith full corridor smoke es open to the corridors that is natic fire department	K	000	EPOC			
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 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.



Protecting, Maintaining and Improving the Health of Minnesotans

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 <u>only a suggestion</u> 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

Sacred Heart Care Center July 11, 2016 Page 2

"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,

Kumala Fiske Downing

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

Minnesc	ta Department of He	alth			-	_
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		00393	B. WING		06/3	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SACRED	HEART CARE CENT	FB	H STREET S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 07/21/16

STATE FORM

If continuation sheet 1 of 34

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00393		B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
SACRED	HEART CARE CENT	FR	H STREET SO MN 55912	DUTHWEST		
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2 000	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On June 27, 28, 29 this Department's s	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. and 30, 2016, surveyors of taff visited the above provider				
	Please indicate in y correction that you and identify the dat In addition, a comp completed at the tir	orrection orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. laint investigation were also ne of the licensing survey. An nplaint H5447008 was a not substantiated.				
2 255	Assurance Commit A nursing home mu assessment and as of the administrator services, the medic designated by the r three other membe representing discip resident care. The assurance committ respect to which qu necessary and dev appropriate plans o quality deficiencies	O Quality Assessment and tee ast maintain a quality surance committee consisting r, the director of nursing cal director or other physician nedical director, and at least rs of the nursing home's staff, lines directly involved in quality assessment and ee must identify issues with nality assurance activities are elop and implement f action to correct identified . The committee must num, incident and accident	2 255			7/21/16

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
00393		B. WING		06/30/2016		
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE		0/2010
SACRED	HEART CARE CENT	FR	H STREET S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 255	Continued From pa	age 2	2 255			
	reporting, infection pharmacy services	control, and medications and				
	This MN Requirem by:	ent is not met as evidenced				
	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.			Corrected		
	Findings include:					
	records, reviewed f revealed the medic meeting held on 7/ 4/11/16 (a period or attendance records	ty's QAA meeting attendance from 7/13/15 to 4/11/16, sal director attended the QAA 13/15 and not again until f nine months). The s revealed no physician meetings held on 9/28/15, 6.				
	coordinator (QAC)- director had not att required quarterly. tried to coordinate to medical director wa he can be present. physician was present. director. The QAC	7 p.m., quality assurance B confirmed the medical ended the QAA meetings as The QAC-B stated the facility the meetings for when the as in the facility for rounds so The QAC-B stated no other ent in place of the medical -B stated she was aware the as not attending the meetings.				
	individuals will serv	undated, indicated the following e on the committee: Medical nittee will meet at least				
necoto D		THOD OF CORRECTION: could educate the physician or				
ATE FORI	-		6899	LKO911	If continuati	on sheet 3 o

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED			
	00393		B. WING						
					06/	30/2016			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SACRED HEART CARE CENTER 1200 12TH STREET SOUTHWEST									
SACREE	DHEART CARE CENT	FR	MN 55912	onwest					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
2 255	Continued From pa	age 3	2 255						
		ive on the importance of activities. Monitoring for to be included too.							
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one							
2 540	MN Rule 4658.040 Resident Assessm	0 Subp. 1 & 2 Comprehensive ent	2 540			7/21/16			
	resident's needs, w capability to perform significant impairm nursing assessmer Minnesota Statutes 15, may be used as resident assessme comprehensive res used to develop, re- comprehensive pla 4658.0405. Subp. 2. Inform comprehensive res include at least the A. medically de medical history; B. medical stat C. physical and D. sensory and E. nutritional s F. special treat	ion; tential; n potential;							

Minnesota Department of Health STATE FORM

6899

LKO911

If continuation sheet 4 of 34

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00393	B. WING		06/30/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
SACRED	HEART CARE CENT	IEB	H STREET S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 540	Continued From pa	age 4	2 540			
	M. drug therap N. resident pre					
		ent is not met as evidenced				
	review, the facilty f	tion, interview, and document ailed to comprehensively oken teeth for 1 of 3 residents dental.		Corrected		
	Findings include:					
	date of 3/26/15. Ac Plan dated 3/26/15 missing teeth." Adu (MDS) dated 4/2/1	ecord indicated an admission dmission Care & Assessment is oral status revealed "some mission Minimum Data Set 5 indicated no dental concerns d 3/10/16 indicated no dental				
	(RN)-A, a nurse maregarding R7's MD was an error on my plan. Every quarter address if he has a	7 p.m. registered nurse anager, was interviewed S dental assessments. "That y part. I will add it to his care r in the care conference we any concerns. He did not have ant to see the dentist."				
	dated 1/5/16 reads Heart Care Center interdisciplinary as condition, in order care that will attain	nt and Care Plan System Policy s, "It is the policy of Sacred to provide a comprehensive sessment of the resident's to develop consistent quality or maintain the highest al, mental, and psychosocial				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00393		B. WING		06/30/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SACRED	HEART CARE CENT	FR	TH STREET S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 540	Continued From pa	age 5	2 540			
	assessment in turn	e. This comprehensive is used to develop and prehensive plan of care."				
	director of nursing develop and impler related to ensuring comprehensive. Th provide training for assessment and as	THOD OF CORRECTION: The (DON) or designee, could nent policies and procedures assessments are le DON or designee, could all nursing staff . The quality ssurance committee could idits to ensure compliance.	•			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			7/21/16
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the cor assessment. The o must include the in	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and record ailed to care plan missing dents (R51) reviewed for		Corrected.		
	Findings include:					

STATE FORM

LKO911

If continuation sheet 6 of 34

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
00393		00393	B. WING		06/30/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SACRED	HEART CARE CENT	I F R	TH STREET SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 6	2 560			
	R51 had two missi	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 pottom gum line).				
	2/3/14, identified of R51's Nursing Ass	ssion Assessment, dated ral status, some missing teeth. essment dated 4/27/16, ailed to identify missing teeth.				
	self-care deficit dre related to weakness balance, ability var supervision and ve anxiety, cognitive in neuropathy, catara legal blindness. Re as needed dental a appointments as re	int date 6/29/16, identified essing, bathing, grooming es, impaired sitting, standing ies day to day, needs rbal cues. Diagnoses of mpairment, anemia, ct, macular degeneration and esident and family prefer only appointments. Facilitate dental esident/family request. own teeth after set up.				
	stated she was res oral assessments a resident's mouth a completed. RN-A s had missing teeth. Admission Assess confirmed the asse some missing teeth Assessment dated failed to identify mi	5 p.m., registered nurse (RN)-A ponsible for completing the and does visually look in the t the time the assessment is tated she was not aware R51 RN-A reviewed R51's facility ment, dated 2/3/14, and essment identified R51 had h and R51's Nursing 4/27/16, oral/dental status ssing teeth. At 3:16 p.m., RN-A				
	observed R51's tee side of R51's mout on the top gum line	eth and confirmed, on the left h, R51 had one missing tooth and bottom gum line. RN-A are plan failed to include				

		Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
	00393		B. WING		06/30/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SACRED	HEART CARE CENT	FR	H STREET S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 560	Continued From pa	ige 7	2 560			
	stated if missing te assessment and if	p.m., the director of nursing eth was identified on the an issue with the resident then Id be on the care plan.				
	System-Care Plan Conference-Interdis indicated Procedur assure that the follo	sciplinary, dated 1/5/16, e 5. The care plan team is to owing areas are addressed d. Completed by the facilitator.				
	director of nursing responsible for dev care plan to include	THOD OF CORRECTION: The could in-service all employees eloping the comprehensive all areas of cares and on the comprehensive				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			7/21/16
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and record ailed to complete facial hair planned for 1 of 1 resident (R5) ies of daily living.		Corrected.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00393		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		06/30/2016		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SACRED	HEART CARE CENT	FR	TH STREET SC MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
	Findings include:					
	and 6/28/16, at 8:4 black/grey facial ha	rved on 6/27/16, at 3:27 p.m. 2 a.m. R5 had long thin air on her chin and upper lip. mum Data Set (MDS) dated				
	3/30/16 indicated s with a Brief Intervie	evere cognitive impairment w for Mental Status (BIMS) ensive physical assist from two				
	in areas of dressing	uded R5 had a self-care deficit g, bathing, and grooming hitive impairment. The care f shave resident."				
	nursing assistant (I days were Thursda could wash her fac take care of nails a residents should be day. NA-C stated it shaved in a while a explained the facilit	v on 6/28/16, at 1:26 p.m. NA)-C reported R5's shower by evenings, and indicated R5 e, and arms. NA-C stated "We and facial hair." NA-C stated e checked for facial hair every looked like R5 had not been and needed to be done. NA-C ty has attempted for family to A-C reported she thought the hunity razor.				
	licensed practical n residents do not ha family to bring one the facility had a cc available if the resid	v on 6/28/16, at 1:32 p.m. hurse (LPN)-B indicated if twe their own razors we contac in for them. LPN-B reported ommunity razor that was dent did not have one. LPN-B ttempts had been made for orking razors.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00393		B. WING		06/	06/30/2016	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2010
SACRED	HEART CARE CENT	FR	TH STREET SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	director of nursing not have a commu purposes and we re provide the razors. did not bring one in resident account. If preferences should staff should follow if resident was not sh documented in the Facility policy Activity Functions) last revit "The purpose of acc provide assistance functions. To super to maintain optimum possible, and to re- life function. The pur- requirements for en- procedures." Facility policies AM Cares, and Hair Ca	(DON) stated, the facility does nity razor for infection control equest family members DON explained if the family then facility would check the DON explained shaving I be included in the care plan, the care plan, and if the naved the reason should be record. ities of Daily Living (Daily Life ewed on 1/5/16 included, tivities of daily living is to to resident for daily life vise resident activities in order m functions as long as reducate in techniques of daily blicy did not include nsuring shaving preferences or (Morning) Care, HS (bedtime)				
	director of nursing review hygiene poli members and prov DON or designee of implement an audit	THOD OF CORRECTION: The (DON) or designee could icies with direct care staff ide education as needed. The could then develop and ting system as part of their o ensure on-going compliance				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
00393		B. WING		06/30/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	
SACRED	HEART CARE CENT	FR	H STREET S MN 55912	GOUTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
2 570	Continued From pa	age 10	2 570		
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570		7/21/16
	for the resident, an disciplines as deter and, to the extent participation of the guardian or choser quarterly and withir	ered nurse with responsibility d other appropriate staff in rmined by the resident's needs, practicable, with the resident, the resident's legal n representative at least n seven days of the revision of resident assessment required subpart 3, item B.			
	by: Based on observat review the facility fa include anxiety syn and ongoing monitu- behaviors, goals w for 1 of 5 residents unnecessary media Findings included: R5's facility admiss of anxiety disorder. R5's quarterly Minit 3/20/16 included di and demonstrated inattention, severe Brief Interview for M The MDS reported	ion record included diagnosis		Corrected.	
	by the facility on 6/3	d physician's orders provided 30/16 included Alprazolam) by mouth as needed (PRN)			

STATEMEI	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
			H STREET SC	DUTHWEST		
SACRE	HEART CARE CENT	ER AUSTIN,	MN 55912			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID DDEELV	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
2 570	Continued From pa	age 11	2 570			
	(shortness of breat date of 3/23/16. Th PRN order for Alpra 0.25 mg every nigh 5/11/16. Physician's Buspirone 15 mg tv start date of 3/31/1 R5's Medication Ad and June 2016 refle Alprazolam 0.25 m twice-daily adminis R5's current care p 6/30/16 did not iden lacked a plan of ca monitoring and inter management. The identification of mo prescribed anti-anx During observation was resting in her k During an observat and at 1:26 p.m. R8 wheelchair. During an interview director of nursing plan and indicated for anxiety and stat stated R5's care pla Facility policy Medi reviewed 2/7/16 inc during the initial an incorporated into a reflects appropriate parameters for more and ongoing need for but not limited to, we responsible fro more	Iministration Record for May ected nightly administration of g (nightly after 5/11/16) and tration of Buspirone 15 mg. lan provided by the facility on ntify diagnosis of anxiety and re for anxiety target behavior erventions for symptom care plan also lacked nitoring and management of ciety medications. s on 6/27/16, at 3:27 p.m. R5 bed with her eyes closed. ions on 6/28/16 at 8:42 a.m. 5 was sitting quietly in her r on 6/28/16, at 2:20 p.m. (DON) reviewed R5's care there was not a plan of care there should be one. DON an would be updated today. cation Management Policy last cluded, "Information gathered d ongoing evaluations are comprehensive care plan that e medication-related goals and nitoring the resident's condition for medication(s), including, <i>v</i> hat is monitored, who will be nitoring, and how often and				

Minneso	ta Department of He	alth				/
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY PLETED
		00393	B. WING		06/3	80/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SACRED	HEART CARE CENT	ER 1200 12TH AUSTIN, M		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 12	2 570			
	sole approach for b interventions will be SUGGESTED MET facility could review the Resident Asses manual, make char procedures as nece provide education t and implement the then develop and ir for the care plan to areas that require a	I, "Medications use is not the ehavioral intervention. Other e identified in the care plan." THOD OF CORRECTION: The policies and procedures and sment Instrument (RAI) nges to existing policies and essary. The facility could then o staff members who develop care plan. The facility could nplement an auditing system ensure all resident assessed a plan of care are addressed. R CORRECTION: Twenty-one				
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv services to maintain and personal and o This MN Requireme by: Based on observati review the facility fa assistants for a dep the care plan for 1 of activities of daily liv Findings included:	is unable to carry out ing receives the necessary n good nutrition, grooming, ral hygiene. ent is not met as evidenced on, interview and document tiled to provide hygiene bendent resident according to of 1 resident (R5) reviewed for	2 920	Corrected.		7/21/16
Minnesota D	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00393	B. WING		— 06/30/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• • • •	
SACRED	HEART CARE CENT	I F R	TH STREET SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	black/grey facial ha R5's quarterly Mini 3/30/16 indicated s with a Brief Intervie score of 4 and exte staff members for p R5's care plan inclu- in areas of dressing related to mild cog- plan directed, "staff During an interview nursing assistant (I days were Thursda could wash her fac breasts. NA-C state facial hair." NA-C state	uded R5 had a self-care deficit g, bathing, and grooming nitive impairment. The care f shave resident." v on 6/28/16, at 1:26 p.m. NA)-C reported R5's shower ay evenings, and indicated R5 re, arms and underneath her ed "we take care of nails and stated residents should be				
	looked like R5 had and needed to be of facility has attempt NA-C reported she community razor. During an interview director of nursing not have a commu purposes and we re	hair every day. NA-C stated it not been shaved in a while done. NA-C explained the ed for family to bring in a razor thought the facility had a v on 6/29/16, at 12:45 p.m. (DON) stated, the facility does nity razor for infection control equest family members DON explained if the family				
	did not bring one ir resident account. I preferences should staff should follow resident was not sh documented in the	then facility would check the DON explained shaving be included in the care plan, the care plan, and if the naved the reason should be				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	1	
SACRED	HEART CARE CENT		TH STREET S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 14	2 920			
	"The purpose of ac provide assistance functions. To super to maintain optimu possible, and to re life function. The p requirements for e procedures." Facility policies AW Cares, and Hair Ca	iewed on 1/5/16 included, ctivities of daily living is to to resident for daily life rvise resident activities in order m functions as long as -educate in techniques of daily olicy did not include nsuring shaving preferences of 1 (Morning) Care, HS (bedtime) are did not include nsuring shaving preferences of	r)			
	director of nursing review hygiene pol members and prov DON or designee of implement an audi quality assurance t	THOD OF CORRECTION: The (DON) or designee could icies with direct care staff <i>v</i> ide education as needed. The could then develop and ting system as part of their to ensure on-going compliance R CORRECTION: Twenty-one				
21380	Direction of Progra Subp. 2. Direction must assign one por or a physician, the	0 Subp. 2 Infection Control; m of program. A nursing home erson, either a registered nurse responsibility of directing stivities in the nursing home.	21380 e			7/21/16
	by: Based on interview	ient is not met as evidenced and record review, the facility registered nurse or physician to		Corrected		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SACRED	HEART CARE CENT	FR	H STREET SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21380	Continued From pa	age 15	21380			
		wide infection program. This effect all residents, staff and				
	Findings include:					
	with diagnosis of C included antibiotic days. Start date 4/5 no other informatio antibiotic was affect cleared. There was	on the April 2016 infection log ellulitis. Documentation of Bactrim DS give one for ten 5/16 and end date 4/15/2016. n found on log. No indication if tive and if cellulitis had a no indication if education of a to lack of trending.				
	for All Nursing Units contained a total ar month. Infections we the facility which ide infection was locate all three months on received antibiotics antibiotics, and stat antibiotics. The infe- residents who had treated with an anti- of infection trends a facility acquired infe- did not reflect docu- measures to stop of	ty's Monthly Infection Report s for April, May and June 2016 mount of infections for each vere color coded on a map of entified which wing each ed. An order listing report for ily indicated residents who had s, indication for use of rt and stop dates of the ection control logs lacked all an infection that was not biotic, an overall assessment and lacked identification of ections. In addition, the logs imentation of preventative or reduce the risk for spread of occurred in the facility during e 2016.				
	infection control nu residents were mor on antibiotics. She have resolved whe	on 6/30/2016 at 2:08 p.m., the rse, (LPN)-A stated that nitored when they were placed stated that the infection should n they were given the last dose stated that the staff should be	9			

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00393	B. WING		06/	06/30/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
SACRED	HEART CARE CENT	FR	H STREET SC MN 55912	DUTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21380		-	21380				
	writing in an infection was resolved or no	on note whether the infection t.					
		ted of the facility's policy and trending infections.					
	director of nursing a nurse to have over	THOD OF CORRECTION: The should assign a registered sight of the entire facility and frequently monitor for					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			7/21/16	
	maintain a comprehification control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines.	t				
	(b) Written complia be maintained by th		t				

Minneso	ta Department of He	alth			PROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SU COMPLE	
		00393	B. WING	06/30/	/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	FR	H STREET SOUTHWEST MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21426	Continued From pa	lge 17	21426		
	by: Based on interview	ent is not met as evidenced and document review, the ure 5 of 5 employees (nursing	Corrected		
	assistant - NA-I, NA RN-C, and dietary a tuberculin skin testi Centers for Disease (CDC) guidelines; f written Tuberculosis to ensure the facilit control procedures	A-J, NA-K, registered nurse - aide - DA-A) received a ing (TST) according to the e Control and Prevention ailed to insure a current s (TB) risk assessment; failed y had written TB infection as required. This had the II residents, staff and visitors.			
	Findings include:				
	LACK OF TWO ST THE CDC GUIDEL	EP TST ACCORDING TO INES FOR STAFF:			
	TST on 2/24/16, an 3/8/16, with reading negative on 2/26/16 documented inform of day the first and	nation failed to include the time second TST's were ne time of day the first and			
	TST on 12/16/15 at mm and negative o	12/14/15, and had a first step t 10:30 a.m., with readings of 0 in 12/16/15. The documented 6/15, failed to include the time was read.			
	step TST on 3/7/16 3/10/16. The docum	10/5/15, and had a second , with readings of 0 mm on nented information failed to day the second TST was			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SACRED	HEART CARE CENT	IFR	TH STREET SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 18	21426			
	second TST was re negative. In additio	he time the time of day the ead and lacked the reading of on, NA-K's record identified a mpleted on 3/7/16 (5 months				
	on 3/22/16, with re The documented in reading of negative identified a TB scre	n 3/15/26, and had a first TST adings of 0 mm on 3/24/16. Information failed to include the e. In addition, RN-C's record een was completed on 3/22/16 and the first TST was not given required.				
	on 10/27/16, with r but failed to include second TST on 2/1 read results of the results of 0 mm or 3/3/16, which failed was administered. identified a TB scree	10/16/15, and had a first TST eading of 0 mm on 10/24/16, e the reading of negative. The 2/16, which failed to include day, the time and documented negative. The third TST on d to include the time the TST In addition, DA-A's record een was completed on fter hire) and the first TST was of hire as required.				
	(LPN)-A stated she positive or negative	5 p.m., licensed practical nurse e did not know the reading of e had to be recorded in addition erified the information as above g.	n			
	Interpretation Resulticensed nurse must test within 48-72 he administered. Reco the results are read	Tuberculin (Mantoux) ults, dated 6/1/12, indicated a st read the results of the TB ours after the test is ord time as well as date that d. ulin (Mantoux) Testing Newly				

STATE FORM

LKO911

If continuation sheet 19 of 34

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
SACRED	HEART CARE CEN	IFR	H STREET SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426		age 19 and Volunteers, dated 9/8/15,	21426			
	indicated licensed baseline TB screen employees/volunte to address an emp patients after a neg	nurse will complete the ning tool for newly hired ers. However, the policy failed loyee may begin working with gative TB symptom scree and a	a			
	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 dated 4/17/12, and confirmed the risk assessment we 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 r will be assessed annually in March of each yea TB INFECTION CONTROL PLAN LACKED TH FOLLOWING:	ector of nursing (DON) TB risk assessment dated med the risk assessment was mpleted assessment the DN stated LPN-A was in the ting a current facility risk ad not yet completed the risk o the county did not have ete the required information. S p.m. LPN-A confirmed the sment completed was dated TB Exposure Control Plan, ated Risk Assessment: the risk nnually in March of each year.				
	Plan, dated 9/8/15 resident assessme dated 4/15/09, incl	ity policy TB Exposure Control , and the facility policy TB ent and transfer/Discharge, uded early recognition and s for TB as required.				
	infection control pr residents with activ information about v public health depa investigation if hea	ies failed to include written TB ocedures for isolation for ve TB and failed to include working with the local or state rtment to conduct a TB contact Ith care-associated tuberculosis is suspected.				

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (۶	(3) DATE SURVEY COMPLETED
		00393	B. WING		06/30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
SACRED	HEART CARE CENT	ER 1200 12TH AUSTIN, M		OUTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
21426	Continued From pa	ige 20	21426		
		p.m., LPN-A confirmed the ked information in regards to			
	The director of nurs	HOD OF CORRECTION: sing could review tuberculosis dures to ensure compliance.			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
21490	MN Rule 4658.100 Updating Assessme	5 Subp. 4 Social Services; ent	21490		7/21/16
	psychosocial asses	the assessment. The ssment must be reviewed at updated as necessary.			
		ent is not met as evidenced			
	review, the facility f assess mood chan increase in depress	ion, interview, and document ailed to comprehensively ges after a substantial sive symptoms for 1 of 5 riewed for unnecessary		Corrected	
	6/28/16, at 9:03 a.n R58 was lying in be During an interview R58 was lying in be question, "I noticed a reason you like to don't know where to	erved on 6/27/16, at 3:07 p.m., n., and 6/29/16 at 11:00 a.m. ed awake. on 6/29/16, at 8:58 a.m. while ed awake. In response to the you stay in your room, is there b be alone?" R58 stated, "I o go or what to do and when I look at me like I'm a stupid			

STATEME	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00393	B. WING			06/30/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•		
		1200 121	H STREET SC	DUTHWEST			
SACREL	D HEART CARE CENT	AUSTIN, I	MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21490	Continued From pa	ge 21	21490				
	depression?" R58 talk to me about it, After several more R58's sentence struc comprehendible for R58 had diagnoses disturbance, major restlessness and ag abnormal weight loa admission record. R58's last Care Are 12/29/15 included, instrument for screa and measuring the of (04) remains low feeling tired (almos occasional down/sa with any of the rem medication therapy beneficial [Celexa, migraines but also Quetiapine]. No add with this review. Wi potential changes in address PRN [as m R58's quarterly Min 3/23/16 did not ider and anxiety, indicat impairment with a E Status (BIMS) score delirium or behavio PHQ-9 score of 3 a reported feelings of however felt tired a every day. The MD2 antipsychotic and a R58's quarterly MD identified diagnosis	r meaning. of dementia with behavioral depressive disorder, gitation, anxiety disorder, and ss according to the facility a Assessment performed on "PHQ-9 [a multipurpose ening, diagnosing, monitoring severity of depression] score . She consistently admits to t all the time) and having ad days but denied difficulty aining items. Current for her depression remains Mirtazapine, Divalproex for used to control mood, and ditional issues or concerns Il continue to monitor for n cognition and mood and eeded]." imum Data Set (MDS) dated ntify diagnosis of depression ed severe cognitive Brief interview for Mental e of four without symptoms of rs. The MDS included a and identified R58 had not being better off dead, nd had little energy nearly					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE. ZIP CODE		
		1200 121	H STREET SC			
SACRED	HEART CARE CENT	FR	MN 55912			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID			(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T		DATE
				DEFICIENC	Y)	
21490	Continued From pa	age 22	21490			
	and anti-depressant medications. The MDS also					
		in medications. The MDS also ognitive impairment with a				
		b. The assessment now				
		g delirium signs and symptoms				
		lisorganized thinking as well as				
		symptoms directed towards				
		during the assessment period.				
		The PHQ-9 reflected a substantial increase in				
	depressive sympto	ms with a score of fifteen				
	indicating major de	pression or moderately				
		9 reported R58 now had				
		better off dead half or more of				
		look back period, had little				
		in doing things nearly every				
		early every day, and feeling				
		and hopeless half or more of				
	the days.	devided 4/11/10 included				
		der dated 4/11/16 included				
	medication) to 15 n	ine (anti-depressant				
		rogress notes reviewed from				
		ogress notes reported				
		r patterns such as resident				
		in her room and they were				
		d reports of other people being				
		vioral progress note dated				
		steady increase in target				
		ing staff of lying to her" from				
	January through Ap					
		it progress note dated 5/17/16				
		staff indicates no new				
		band recently died, which she				
		r." Physician note identified				
		be mild. Physician progress				
		had weight loss likely related				
		er, physician indicated the				
		altering medication) was				
		5 milligrams (mg) three times ice per day related to weight				
		adverse drug reaction.				
	epartment of Health					

Minnesota Department of Health STATE FORM

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STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
		1200 12TI	H STREET SC			
SACREL	D HEART CARE CENT	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21490	Continued From pa	ge 23	21490			
	a.m. included, "RE PHQ-9 score of (15 decline in mood, sir so vocal during our was able to stay on one of the items re responses. She rea interest in doing this eyesight/hearing per frustrated & depress tired on a daily basid difficulty concentrated dead. "They can just wait for me to die" we denied any potentia and went on to state has likely had these months, but per reach has consistently de asked. [R58] conting of her time resting in has been baseline in not worse or more of [symptoms] present to visit with, and do personal attention. time. Will continue changes in cognition needed]." R58's record lacked assessment followid depressive mood so feeling better off de though R58's spous decrease in two more increase in delusion patterns. The reco- documentation of p	ng the substantial increase in ymptoms and of statements of ad in the last quarter even se had died, there had been a bod altering medications and hal and physical behavior				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			B. WING			
		00393			06/	30/2016
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
SACRED	HEART CARE CENT	FR	H STREET SO MN 55912	JUTHWEST		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21490	Continued From pa	age 24	21490			
	6/30/16 identified p	otential for mood alteration				
		on, anxiety, and dementia. The				
		the increase of mood score of				
	•	oderate depression. The care				
		reported little to no interest in				
		s/frustration, occasional				
		daily, feels bad about self and				
		nts of being better off dead				
		care plan identified R58				
	family.	ed when not visiting with				
		entified and included				
		ated 11/19/14 to manage				
	mood alterations as					
		al doctor as needed				
	 facilitate appoir 	ntment with psych and/or				
	mental services as	needed				
		cy and adverse consequences				
	of medications,					
		anges/decline in mood and				
	address as needed					
		nonitor, intervene or counsel				
	as appropriate/nec	d record lacked evidence the				
		updated after the change in				
	mood score from fo					
		v on 6/9/16, at 9:06 a.m.				
		NA)-D stated we try to get R58				
		as we can and she stays in				
		s tired or has pain. NA-Ď				
		or she was not aware of				
		sive symptoms or had recently				
		hat she felt she would be better				
		was aware R58's husband had				
		vay and indicated R58 was not				
		D explained R58 since be in her room and in bed a lot.				
		ot do a lot of wondering.				
		<i>i</i> on 6/29/16, at 9:19 a.m.				
			1			1

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00393			06/	30/2016
NAME OF	PROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE			
CVUDEL	HEART CARE CEN	1200 12T	H STREET SC	DUTHWEST		
SACHEL		AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21490	Continued From pa	age 25	21490			
	admission. LPN-C her room as much was not aware R58 feelings she would increase in depress indicated she had u increase in depress aware if or how soo LPN-C explained if symptoms then nu medical record, no members to see if During an interview activities assistant from 1:1 visits in he sensory one to one not aware of the re symptoms and R58 dead. During an interview licensed social wor notified the nurse r PHQ-9 score, and implemented anyth increase in score s LSW explained the have been situation written a detailed p plan to include PHG implemented the in monitor. LSW repor things that you can whether they work had not been upda status and would b the scheduled care the PHQ-9 score c depending on how	ut of her room since time of stated staff try to get her out of as possible. LPN-C stated she be better off dead or the sive symptoms. LPN-C not personally seen an sive symptoms and was not cial services was involved. There was an increase in rsing would document in the tify the physician and family therapy services were needed. Y on 6/29/16, at 9:25 a.m. (AA)-A stated R58 benefited er room and was provided e visits. AA-A stated she was cent increase in depressive B's feelings of being better off Y on 6/29/16, at 9:30 a.m. with tker (LSW) stated she had nanager of the increase in the stated, "I don't know that I ning" as a result of the showing worsening depression. Increase in symptoms could hal. LSW stated she had rogress note, updated the care Q-9 score changes, and had tervention of continue to orted, "To me interventions are try they are not solutions, or not." LSW stated the family ted of the change in mood e updated today (6/29/16) at e conference. LSW explained ould change from day to day R58 was feeling at the time of ver LSW stated she had not				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
SACRE	D HEART CARE CENT	IFR	H STREET SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21490	Continued From pa	age 26	21490	DEHOIENO	')	
	PHQ-9 assessmer residents psychoso social services visi were not based on psychotropic media question, "How do symptoms?" LSW mood she has a rig have to take the tir find if something is outside referral for been considered o increase in depres statements of bein During an interview reported she was right depressive sympton better off dead. During an interview LPN-A reported sh feeling of being be aware of the increat During an interview registered nurse (Fi been made aware by the social worked reported the chang RN-A explained the record) system ide assessments by se of need for further RN-A stated a ware a result of the increat by the social worked reported the chang RN-A explained the record) system ide assessments by se of need for further RN-A stated a ware by the social worked reported the chang RN-A explained the record system ide assessments by se of need for further a result of the increat by the social worked reported the chang result of the increat by the social worked reported the chang	v on 6/29/16, at 9:48 a.m. NA-E not aware of any increase in oms or R58's feelings of being v on 6/29/16, at 9:51 a.m. e was not aware of R58's tter off dead and was not ase in depressive symptoms. v on 6/29/16, at 12:00 p.m. RN)-A indicated she had not of the mood status as reported er. RN-A stated LSW had ge this morning (6/29/16) to her e EHR (electronic health ntifies changes on ending out warning messages assessment and intervention. ning message was created as ease in the PHQ-9 score on he social worker had signed ting the alert was addressed completed. RN-A stated, if she f the mood change score				

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00393	B. WING		06/	30/2016
ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
IEART CARE CENT	FR		DUTHWEST		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
comprehensive mo he possible root ca depressive symptor indings as well as of and implement imm explained the proce he resident has de mpairments, the m addressed. During an interview director of nursing (he score on the PH addressed and repo- nterventions put int have been followed A facility policy pert services was reque facility policy Media ncluded necessary and care plan revis performed by nursin continued medication address procedures symptoms. SUGGESTED MET acility could review nursing services po- changes as needed review/develop and members on depre- management for re acility could develo approach between services to ensure of ndividualized interv	od assessment to determine ause of the increase in ms, notify the physician of the direct care staff, and develop nediate interventions. RN-A ass is the same regardless if mentia and/or memory ood change needs to be f on 6/29/16, at 12:23 p.m. (DON) stated the changes of AQ-9 should have been orted immediately and to place. DON stated, it should up on. aining providing social sted and not received. cation Management Policy, requirements for assessment ion based on evaluations ng staff to justify the use of ons. The policy did not s for increases in depressive THOD OF CORRECTION: The their social services and dicies and procedures; make d. The facility could then provide education to staff ssion and mood/behavioral sidents with dementia. The op a comprehensive system social services and nursing comprehensive assessments, ventions and follow-up are		DEFICIENC	(Υ)	
	OF DEFICIENCIES F CORRECTION INVIDER OR SUPPLIER IEART CARE CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa comprehensive mo he possible root ca depressive symptor indings as well as of and implement imm explained the proce he resident has de mpairments, the m addressed. During an interview director of nursing (he score on the PH addressed and repu- nterventions put im- nave been followed A facility policy pert services was reque facility policy Media ncluded necessary and care plan revis berformed by nursing continued medication address procedures symptoms. SUGGESTED MET acility could review nursing services po- changes as needed review/develop and members on depre- management for re acility could develo approach between services to ensure of ndividualized intervi-	F CORRECTION IDENTIFICATION NUMBER: 00393 000000000000000000000000000000000000	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: B. WING O0393 STREET ADDRESS, CITY, STREET ADDRESS, STREET,	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:	OP DEFICIENCIES F CORRECTION (M) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: 00393 (M2) MULTIPLE CONSTRUCTION A BUILDING:

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		00393	B. WING		06/30/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SACRED	HEART CARE CEN	IFR	H STREET SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21490	Continued From pa	age 28	21490			
	compliance.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.131 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary eral	21535			7/21/16
	must be free from unnecessary drug A. in excessive therapy; B. for excessive C. without ade D. in the prese which indicate the discontinued. In addition to the c part 4658.1310, th with provisions in t Code of Federal R 483.25 (1) found in Operations Manua Long-Term Care F Department of Hea Health Care Finand This standard is in available through t	quate indications for its use; or ence of adverse consequences dose should be reduced or drug regimen review required in the nursing home must comply he Interpretive Guidelines for egulations, title 42, section a Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not				
	by: Based on observat review, the facility behaviors to detern	ient is not met as evidenced tion, interview and record failed to identify specific target nine efficacy for the use of an tipsychotic medications for 1 of		Corrected		

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		1200 127	H STREET SC	DUTHWEST		
SACRED	HEART CARE CENT	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ige 29	21535			
	5 residents (R57) remedications.	eviewed for unnecessary				
	Findings include:					
	indicated that the re post-traumatic stread disorder, mild cogn	cord, dated, 9/25/2014, esident had diagnoses of ss disorder, major depressive itive impairment, panic th personality disorder and o disorder.				
	that the resident ha Risperidone (an an (milligrams) to be ta related to major de R57 had been pres antianxiety medicat	tipsychotic medication) 2 mg aken by mouth at bedtime pressive disorder. In addition, cribed Lorazepam (an tion), dated 11/13/15. She was nouth three times a day related				
		imum Data Set (MDS), dated hat the resident was				
	dated 5/24/16, indic taking 0.5 mg of Ati addition to Risperda stated that she suff and generalized an behaviors consisted	e medication assessment, cated that the resident was ivan three times a day in al 2 mg every evening. It fered from major depression xiety. It stated that her d of statements of sadness				
	it stated that R57 h mental illness and i	and not sleeping. In summary ad long term problems with use of psychotropic ommended to continue to	,			
	monitor the efficacy that R57 was readr	y of the medications. It stated nitted back to the facility on rders for Risperdal. R57 did				

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	DRESS, CITY, STATE, ZIP CODE		
SACRED	HEART CARE CENT	FR	H STREET SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ige 30	21535			
		al comments this month. It ontinue to same plan of care.				
	reviewed from 6/1/-	dministration record (MAR), 13 through 6/30/16, indicated d been taking the Ativan and ribed.				
	resident had a pote to diagnoses of any dependent personal lengthy psychologic stays in a behaviora history of electroco suicidal ideation. R health which R57 re a history of tongue thrusting the lower the staff to monitor in her mood and ac care plan also reco psychological medi facility policy. It adv	ted 10/3/2014, stated that the ential for altered mood related kiety, depression, panic and lity disorder. R57 had a cal history with prior hospital al healthcare unit and had a nvulsive treatment along with 57 was followed by mental eported as beneficial. R57 had thrusting and sucking and lip. The care plan encouraged R57 for changes and declines ldress them as needed. The mmended to monitor her cation as directed by the rised to question R57 about sions, wanting to die and if ommit suicide.				
	stated that the residence of the stated that the residence of the state of the stat	ress note, dated 6/6/2016, dent remained fragile h contributed to difficult apuetic management. It stated st be done about R57's				
	was asked which ty exhibited when she	on 6/29/2016 at 1:19 p.m., R57 ppes of behaviors she became anxious. She stated anxious she tended to isolate company.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00393	B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SACRED	HEART CARE CENT	FR	TH STREET SC MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21535	When interviewed nursing assistant (I behaviors and mod instructed to notify document. NA-F st angry if someone w stated that R57 did roommate and wou been resolved. Wh isolate herself, NA- tendency to isolate she saw R57 isolate week. When asked NA-F stated no but when R57 had gon seeing things and the When interviewed NA-G was asked w been instructed to to document. NA-G any behaviors that stated that she did R57 did not exhibit tended to isolate he isolated herself. W hallucinations or de well. When interviewed NA-H stated that s any behaviors such or delusions. NA-H heard that R57 was thoughts of killing h	on 6/29/16 at 1:32 p.m. NA)-F was asked what target od symptoms she had been the nurses in order to tated that R57 would get very were to call her a man. NA-F I not get along with a previous uld say things but that had then asked if R57 did tend to -F stated that R57 did have a herself a lot. NA-F stated that te herself once or twice a d if R57 had any hallucinations, t stated a couple months ago te to the hospital she was			Υ)	
nnocota D	registered nurse (F	on 6/30/16 at 10:35 a.m., RN)-B stated that R57's escribed both the Ativan and				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00393	B. WING		06/30/2016	
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		00,2010
		1200 12T	H STREET SC			
ACRED	HEART CARE CENT	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21535	Continued From pa	age 32	21535			
	not prescribe these asked what specifi staff had been more two medications we stated R57 had be suicidal comments started on Risperd she had been in the the Ativan had not just prescribed. RN on the medication When asked what anxiety R57 had ex	's primary care physician did e medications. RN-B was c target behaviors the nursing hitoring for to determine if the ere affective or not. RN-B en monitored for making . RN-B stated that R57 had al back in August 2015 when e hospital. RN-B stated that been something that R57 was J-B stated that R57 had been prior to coming to the facility. resident centered behaviors of khibited RN-B stated that R57 ent repetitive health complaints her anxiety.				
	stated that R57 ha features. She state on Risperdal and o interdisciplinary tea behaviors. She sta that R57 had exhib	on 6/30/16 at 12:30 p.m., RN- d never exhibited psychotic ed when R57 had been placed same back to the facility, the am (IDT) had reviewed her ted at the time the only thing bited was that one time R57 al comment and so the nursing onitoring for that.				
	director of nursing lack of mood and b	on 6/30/16 at 2:32 p.m., the (DON) was informed of the behavior monitoring. The DON Id have been identified and				
	Procedure, last rev that each resident's from unnecessary unnecessary drugs without adequate r	chotropic Medication Policy and viewed on 2/6/2014, it stated s drug regimen must be free medications. It identified s as any medication used nonitoring. When antipsychotic tiated, it stated that the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00393	B. WING		06/3	30/2016
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S TH STREET SC			
SACRED	HEART CARE CENT	FR	MN 55912	011111231		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21535	Continued From pa	age 33	21535			
	effectiveness of the	ored to determine the e medication. Behaviors were on the behavior documenting				
	The director of nur policies and proced medications and th monitoring to deter psychoactive medi	THOD OF CORRECTION: sing could review and revise dures for unnecessary he need for target/mood mine effectiveness of each cation. Director of nursing f. Director of nursing could e.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				