#### CENTERS FOR MEDICARE & MEDICAID SERVICES

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

WEDICHE CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XO2U Facility ID: 00452

MEDICARE/MEDICAID PROVIDER     (L1) 245454      2.STATE VENDOR OR MEDICAID NO.     (L2) 475213900	NO.	3. NAME AND AD (L3) <b>SANDSTON</b> (L4) <b>109 COURT</b> (L5) <b>SANDSTON</b>	E HEALTH CA AVENUE SOU	RE CENT	(L6) <b>55072</b>	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
<ul> <li>5. EFFECTIVE DATE CHANGE OF OW (L9) 05/17/2017</li> <li>6. DATE OF SURVEY 08/13/</li> </ul>		7. PROVIDER/SUI 01 Hospital 02 SNF/NF/Dual	PPLIER CATEGO 05 HHA 06 PRTF	RY 09 ESRD 10 NF	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35)  09/30
11LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	<b>45</b> (L18) <b>45</b> (L17)	Compliance1.		ram	And/Or Approved Waivers Of Th  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNF  5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOW  18 SNF 18/19 SNF  45  (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)	veis.	* Code: <b>A</b> 15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABL	E SHOW LTC CANCE	ELLATION DATE	):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
				1		
Teresa Ament, Unit Su	pervisor		08/15/2018	(L19)	Joanne Simon, Enfo	orcement Specialist 08/15/2018 (L20)
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	ART II - TO BI	E COMPLETED  20. COM		EGIONAI	L OFFICE OR SINGLE ST. 21. 1. Statement of Finan	ATE AGENCY  ncial Solvency (HCFA-2572)  Il Interest Disclosure Stmt (HCFA-1513)
19. DETERMINATION OF ELIGIBILIT	ART II - TO BE	20. COMPLETED 20. COMPLETED EDIT 22.	BY HCFA RE	EGIONAI CIVIL ENT	21. 1. Statement of Finan 2. Ownership/Contro 3. Both of the Above  26. TERMINATION ACTION: VOLUNTARY 00	(L20)  ATE AGENCY  Incial Solvency (HCFA-2572)  I Interest Disclosure Stmt (HCFA-1513)  (L30)  INVOLUNTARY
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Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245454

August 15, 2018

Mr. Tom Opatz, Administrator Sandstone Health Care Center 109 Court Avenue South Sandstone, MN 55072

Dear Mr. Opatz:

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 26, 2018 the above facility is recommended for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 15, 2018

Mr. Tom Opatz, Administrator Sandstone Health Care Center 109 Court Avenue South Sandstone, MN 55072

RE: Project Number S5454028 and H5454010

Dear Mr. Opatz:

On July 5, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 21, 2018 that included an investigation of complaint number H5454010. This survey found the most serious deficiencies to be widespread 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, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 21, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 26, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 21, 2018, effective July 26, 2018 and therefore remedies outlined in our letter to you dated July 5, 2018, 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,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

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#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFIC	CATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY T	HE STATE SURVEY AGENCY

ID: XO2U Facility ID: 00452

MEDICARE/MEDICAID PROVIDER NO.     (L1) 245454      2.STATE VENDOR OR MEDICAID NO.     (L2) 475213900	3. NAME AND ADDRES (L3) SANDSTONE HE (L4) 109 COURT AVE (L5) SANDSTONE, M	EALTH CARE CENTE ENUE SOUTH	(L6) 55072	4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP  (L9) <b>05/17/2017</b> 6. DATE OF SURVEY <b>06/21/2018</b> (L34) 8. ACCREDITATION STATUS: (L10)	02 SNF/NF/Dual 06	ER CATEGORY  HHA 09 ESRD  PRTF 10 NF  X-Ray 11 ICF/IID	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC	8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08	OPT/SP 12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds 45 (L18)  13.Total Certified Beds 45 (L17)	10.THE FACILITY IS CE  A. In Compliance W Program Require Compliance Base1. Accept  X B. Not in Complian	Tith ements sed On: table POC	And/Or Approved Waivers Of The2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF)5. Life Safety Code	6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room
14. LTC CERTIFIED BED BREAKDOWN	Requirements and/or	Applied waivers:	* Code: <b>B*</b> 15. FACILITY MEETS	(L12)
18 SNF 18/19 SNF 19 SNF 45	ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39)	(L42)	(L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICAB	LE SHOW LTC CANCELLAT	TION DATE):		
17. SURVEYOR SIGNATURE	Date:		18. STATE SURVEY AGENCY A	PPROVAL Date:
Kimberly Settergren, HFE NE I	07/20	0/2018 (L19)	Douglas Larson, Enfo	rcement Specialist 07/30/2018
		(L19)	Douglas Larson, Enfo	(L20)
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PART II - TO B  19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Participate 2. Facility is not Eligible	E COMPLETED BY I  20. COMPLIA RIGHTS	(L19)  HCFA REGIONAL  NCE WITH CIVIL	21. 1. Statement of Finand 2. Ownership/Control	(L20) ATE AGENCY  cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 5, 2018

Mr. Tom Opatz, Administrator Sandstone Health Care Center 109 Court Avenue South Sandstone, MN 55072

RE: Project Number S5454028

Dear Mr. Opatz:

On June 21, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the June 21, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5454010.

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 electronically attached CMS-2567 whereby corrections are required.

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us

Phone: (218) 302-6151 Fax: (218) 723-2359

#### 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 July 31, 2018, 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 July 31, 2018 the following remedy will be imposed:

• 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

Sandstone Health Care Center July 5, 2018 Page 4

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 21, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new

Sandstone Health Care Center July 5, 2018 Page 5

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 21, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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 Sandstone Health Care Center July 5, 2018 Page 6

> 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,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Downes Stapson

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 07/23/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION (2	X3) DATE SURVEY COMPLETED
		245454	B. WING		C <b>06/21/2018</b>
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072	00/21/2010
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 000	Initial Comments		E 00	0	
E 007	Preparedness Req 6/18/18, through 6/ survey. The facility Appendix Z Emerge Requirements. EP Program Patien	t Population	E 00	7	7/20/18
SS=C	[(a) Emergency Pla and maintain an en that must be review	n. The [facility] must develop nergency preparedness plan ved, and updated at least must do the following:]			
	but not limited to, p services the [facility an emergency; and	/client population, including, ersons at-risk; the type of /] has the ability to provide in continuity of operations, ns of authority and succession			
	hospice, PACE, HH FQHC, or ESRD fa	risk" does not apply to: ASC, IA, CORF, CMCH, RHC, cilities.] NT is not met as evidenced			
	Based on interview facility failed to add including, but not lir type of services the provide in an emergoperations, includin succession plan in	and document review, the ress patient/client population mited to persons at-risk; the facility has the ability to gency; and continuity of gelegations of authority and their emergency preparedness potential to affect all 37 the facility.		The Emergency plan will be updated address the entire resident population and address persons at risk and type services the facility can provide in an emergency. The plan will also included elegations of authority and success plans.	n, e of l le
	Findings include:				
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed 07/13/2018

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	COM	E SURVEY MPLETED
		245454	B. WING _			C <b>21/2018</b>
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072	1 00/	21/2010
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E 007	Continued From pa		E 00	7		
	components about persons at-risk, the has the ability to protect the continuity of open of authority and successful and maintain an emthat must be review annually. The plan is component of the maintain an integration of the such officials and, we have components for the (EP) requirements. The facility did not hincluded the specific population: the person services the facility emergency, and the including delegation plans.  Local, State, Tribal CFR(s): 483.73(a)(a) [(a) Emergency Pla and maintain an emthat must be review annually. The plan is collaboration with local process collaboration with local process collaboration of the such officials and, we will be such officials and the such officials are such officials and the such officials are such officials and the such officials and the such officials and the such officials are such officials and the such o	a.m. the administrator and ated the facility had conducted as part of their emergency at completed all of the required emergency preparedness. The administrator confirmed ave an emergency plan that cs about their resident sons at-risk, the type of has the ability to provide in an econtinuity of operations, as of authority and succession.	E 00	9		7/20/18

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245454	B. WING			C <b>21/2018</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	•	21/2016	
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E 009	* [For ESRD facilities Include a process for collaboration with lot Federal emergency to maintain an integration of the contact such official participation in collar planning efforts. The local emergency least annually to coof the dialysis facility emergency. This REQUIREMENT by:  Based on interview facility failed to ensucollaboration efforts emergency prepared the potential to affer in the facility.  Findings include:  The facility emerge 5/17/17, identified to emergency contact coordination and copertinent authorities.  On 6/19/18, at 9:00 (PM) stated she have mergency contact memorandums of udocumentation to independent and the integral of the counterpart of the cou	es only at §494.62(a)(4)]: (4) or cooperation and ocal, tribal, regional, State, and or preparedness officials' efforts grated response during a necy situation, including ne dialysis facility's efforts to ls and, when applicable, of its aborative and cooperative e dialysis facility must contact by preparedness agency at an infirm that the agency is aware by's needs in the event of an every some of an event of a	EO	The facility will collaborate effolocal and state emergency preauthorities to develop and main emergency preparedness plan will also be reviewed annually.	paredness ntain an		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION (2	X3) DATE SURVEY COMPLETED
		245454	B. WING		C <b>06/21/2018</b>
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E 026	CFR(s): 483.73(b)( [(b) Policies and prodevelop and impler policies and proced plan set forth in parassessment at para and the communicathis section. The poreviewed and upda minimum, the policiaddress the following (8) [(6), (6)(C)(iv), (facility] under a wain accordance with provision of care arcare site identified officials.  *[For RNHCls at §4 procedures. (8) The waiver declared by with section 1135 of at an alternative care an agement official This REQUIREMENT.	ver Declared by Secretary 8)  cocedures. The [facilities] must ment emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least annually. At a res and procedures must ng:]  7), or (9)] The role of the iver declared by the Secretary, section 1135 of the Act, in the nd treatment at an alternate by emergency management  03.748(b):] Policies and re role of the RNHCI under a the Secretary, in accordance of Act, in the provision of care re site identified by emergency	E 026	3	7/20/18
	facility failed to ens procedures address under a waiver dec accordance with se provision of care ar care site identified	v and document review, the ure their policies and sed the role of the facility lared by the Secretary, in action 1135 of the Act, in the not treatment at an alternate by emergency management ne potential to affect all 37 in the facility.		The facility will develop a policy and procedure which address the role of facility under a declared waiver by th secretary of state. It will be in accord with section 1135 of the act.	е

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		245454	B. WING	· · ·	1	C / <b>21/2018</b>
	OVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072	1 00/	21/2010
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E 033 M SS=C ( C C C C C C C C C C C C C C C C C C	coinder failed to include of the facility unity and a difference facility unity and a difference facility. On 6/19/18, at 9:00 project manager (Pan emergency was nave a policy writte Methods for Sharin CFR(s): 483.73(c)(d) (c) The [facility] must be reviewed annually.] The companient of the following:  4) A method for shadocumentation for pare, as necessary maintain the continuation of the facility of the facility of the facility.  5) A means, in the felease patient information of pare, as necessary maintain the continuation of the facility.  6) A means in the felease patient information of facility.  6) (a) (b) (c) (c) (c) (d) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	ncy preparedness plan and ude a policy or to address the order a waiver by the Secretary ty or evacuation site.  a.m. the administrator and M) stated this would be done if declared, but they did not n on it. g Information 4)-(6)  ast develop and maintain an edness communication plan Federal, State and local laws ared and updated at least amunication plan must include aring information and medical patients under the [facility's], with other health providers to uity of care.  event of an evacuation, to rmation as permitted under 45 (ii). [This provision is not under §484.22(c), CORFs and RHCs/FQHCs under	ΕO			7/20/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION  NG		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER  ONE HEALTH CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		2112010
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E 033	*[For RNHCIs at §4 sharing information patients under the F with care providers care, based on the made by the patient representative.  *[For RHCs/FQHCs of providing information and locatifacility's care as per 164.510(b)(4). This REQUIREMENT by:  Based on interview facility failed to deven which included a mand medical document the facility care with maintain the continupotential to affect all facility.  Findings include:  On 6/19/18, at 9:00 policies and proced administrator and providers care in patients.	03.748(c):] (4) A method for and care documentation for RNHCl's care, as necessary, to maintain the continuity of written election statement	ΕO	The facility will develop a complan which includes the method information and medical docum for residents under the care of provider and will provide conting in the event of an emergency.	d of sharing nentation the	
E 034 SS=C	did not develop a co included a method i medical documenta	ommunication plan, which for sharing information and tion for residents under the er health providers to uity of care.	E 0	34		7/20/18

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C
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	PROVIDER OR SUPPLIER  ONE HEALTH CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	
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E 034	emergency prepare that complies with F and must be review annually.] The com all of the following:  (7) [(5) or (6)] A me about the [facility's] ability to provide as having jurisdiction, Center, or designed *[For ASCs at 416.5] providing informatic its ability to provide having jurisdiction, Center, or designed *[For Inpatient Hosp of providing information inpatient occupancy provide assistance, jurisdiction, the Incidesignee.  This REQUIREMENT by:  Based on interview facility failed to enspreparedness commeans of providing occupancy, needs, assistance to the autocident Command	ust develop and maintain an edness communication plan Federal, State and local laws wed and updated at least munication plan must include ans of providing information occupancy, needs, and its sistance, to the authority the Incident Command e.  54(c)]: (7) A means of on about the ASC's needs, and assistance, to the authority the Incident Command	E 03	Facility will develop an emerge preparedness communication pwill provide information about the occupancy needs and its ability assistance to the authority having jurisdiction.	olan which ne facilities to provide

	MENT OF DEFICIENCIES LAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245454	B. WING		C 06/21	/2018
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072	1 00/21	72010
(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  CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
	Preparedness Plan and failed to include the communication needs, and the gen residents. The adm had not developed	a.m. the Emergency dated 5/17/17, was reviewed a policy/procedure related to of the facility's occupancy, eral condition and location of inistrator confirmed the facility a policy.	E 034			
	CFR(s): 483.73(c)(s) [(c) The [LTC facility and maintain an emonomunication plan State and local laws updated at least an plan must include at (8) A method for shemergency plan, this appropriate, with families or represer This REQUIREMENTS.	y and ICF/IID] must develop nergency preparedness in that complies with Federal, is and must be reviewed and nually.] The communication II of the following:  aring information from the at the facility has determined residents [or clients] and their intatives.  IT is not met as evidenced	E 035			/20/18
	facility failed to dever preparedness commincluded a method information from the family members. The all 37 residents curre well as their families. Findings include:	munication plan which for sharing appropriate e plan to the residents and his had the potential to affect rently residing the facility, as and/or representatives.		The facility will develop an emerging preparedness communication plar sharing appropriate information to residents and family members.	n for	
	Preparedness Plan administrator and the	a.m. the facility Emergency was reviewed with the ne project manager (PM), who did not address the method				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245454	B. WING			C / <b>21/2018</b>
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		72172010
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E 035	and families. The P considered sharing	tion for the plan with residents M stated they had not the plan with residents or ot yet considered what would	ΕO	35		
E 039 SS=C	EP Testing Require CFR(s): 483.73(d)(	ments	ΕO	39		7/20/18
	The LTC facility mu the emergency plar unannounced staff	at §483.73(d):] (2) Testing. st conduct exercises to test at least annually, including drills using the emergency C facility must do all of the				
	community-based of exercise is not acceptable. If the actual natural or marequires activation [facility] is exempt from community-based of full-scale exercise from the actual event.  (ii) Conduct an addinclude, but is not line (A) A second full community-based of (B) A tabletop exercise of the actual event.	ull-scale exercise that is or when a community-based essible, an individual, a [facility] experiences an an-made emergency that of the emergency plan, the rom engaging in a or individual, facility-based for 1 year following the onset of attional exercise that may mitted to the following: -scale exercise that is or individual, facility-based. ercise that includes a group facilitator, using a narrated, mergency scenario, and a set				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245454	B. WING				21/2018
	PROVIDER OR SUPPLIER ONE HEALTH CARE			109	REET ADDRESS, CITY, STATE, ZIP CODE 9 COURT AVENUE SOUTH ANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	prepared question emergency plan. (iii) Analyze the [famaintain document exercises, and em [facility's] emergent* [For RNHCIs at § §486.360] (d)(2) To must conduct exerplan. The [RNHCI following: (i) Conduct a papeleast annually. A tadiscussion led by a clinically relevant exercises and emergency plan. (ii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan. (iii) Analyze the [R to and maintain doexercises, and emergency plan.	ents, directed messages, or so designed to challenge an cility's] response to and tation of all drills, tabletop ergency events, and revise the explan, as needed.  403.748 and OPOs at esting. The [RNHCI and OPO] roises to test the emergency and OPO] must do the er-based, tabletop exercise at abletop exercise is a group a facilitator, using a narrated, emergency scenario, and a set ents, directed messages, or so designed to challenge an NHCI's and OPO's] response examentation of all tabletop ergency events, and revise the D's] emergency plan, as examined and document review, the sure efforts to participate in a ity or tabletop exercise had This had the potential to affect siding in the facility.	EO	39	The facility will coordinate and part in a tabletop exercise to test the emergency plan and coordinate a do a full scale exercise at a minimu annually. This meeting is schedule Tuesday, August 7th @ 1pm. We h representatives coming from the fo places: Essentia Sandstone, hospit Golden Horizons AL, Sandstone Cir Administrator, Pine county emerger preparedness - 2 reps, Sandstone chief, Don Sheldrew from East Cen	late to im of d for ave llowing al, ty ncy fire	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245454	B. WING				C <b>21/2018</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/2	21/2010
SANDST	ONE HEALTH CARE	CENTER			9 COURT AVENUE SOUTH ANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	exercise or tabletop exercise. The EPP failed to provide direction to participate in a full-scale		E 0	39	Emergency Preparedness Coalition Sandstone Ambulance representat		
F 000	Community exercises On 6/19/18, at 9:00 project manager (P planned or participa community exercises internally responder 6/16/16, but had no planning, coordinate	a.m. the administrator and M) confirmed they had not yet ated in a full-scale or table top e. The PM stated they had d to a tornado warning on t done any community based ion or exercises.	F.00	00	and Rose from the Sandstone golf - where our evacuation site is. The following 3 people will represent Sandstone Health Care Center: To Opatz Administrator, Erica Stapek, DON and Jennifer Colby EP stewar	course n RN	
F 000	through 6/21/18, 20 investigation(s) wer of the standard sur	rvey was conducted 6/18/18, 118 and complaint re also completed at the time vey.	F 00	00			
	complaint #H54540	urvey, an investigation of 10 was completed and was ntiated at F580 and F726.					
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are our signature is not required of first page of the CMS-2567 of submission of the POC will cion of compliance.					
<b>-</b>	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with					7/10/12
F 580 SS=D		Injury/Decline/Room, etc.) 14)(i)-(iv)(15)	F 58	80			7/13/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	CON	TE SURVEY MPLETED
		245454	B. WING _			C / <b>21/2018</b>
	PROVIDER OR SUPPLIER ONE HEALTH CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	§483.10(g)(14) Not (i) A facility must im consult with the resconsistent with his representative(s) w (A) An accident invresults in injury and physician interventi (B) A significant chamental, or psychos deterioration in heastatus in either lifeclinical complication (C) A need to alter a need to discontint treatment due to accommence a new f (D) A decision to travesident from the fa §483.15(c)(1)(ii). (ii) When making n (14)(i) of this sectionall pertinent informatic available and prophysician. (iii) The facility must resident and the rewhen there is-(A) A change in rocas specified in §483 (B) A change in resultant (b) (10) of this section (iv) The facility must resident and the resultant control of the section (iv) The facility must resident and the resultant control of this section (iv) The facility must resident and the resultant control of this section (iv) The facility must resident and the resultant control of this section (iv) The facility must resident and the resultant control of this section (iv) The facility must resident and the resultant control of the section (iv) The facility must resident and the resultant control of this section (iv) The facility must resident and the resultant control of the section (iv) The facility must resident and the resultant control of the section (iv) The facility must resident and the resultant resident and the resultant resident and the resultant resident re	ification of Changes. Immediately inform the resident; Indent's physician; and notify, or her authority, the resident I hen there is- olving the resident which I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a Ilth, mental, or psychosocial threatening conditions or ins); treatment significantly (that is, ue an existing form of diverse consequences, or to form of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) in, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the sident representative, if any, om or roommate assignment 3.10(e)(6); or ident rights under Federal or tions as specified in paragraph on. st record and periodically is (mailing and email) and	F 58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245454	B. WING		06/2	21/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2	1/2010
SANDST	ONE HEALTH CARE	CENTER		109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
	OLIMAN DV OT	ATEMENT OF RESIDIENCIES		·		
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	that is a composite §483.5) must disclist physical configurations that compart, and must speroom changes between §483.15(c)(§ This REQUIREME by: Based on interview facility failed to ensupon a change in configuration (R18, R25) reviews  Findings include:  R18's Admission Raincluded diagnoses	inposite distinct part. A facility distinct part (as defined in ose in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to ween its different locations b).  NT is not met as evidenced ov, and document review, the sure the physician was notified condition for 2 of 4 residents and for notification of change.	F 58	Element #1: Resident R18 & R25 sugars were reviewed and any cowere brought to MD/NP's attention Element #2: All other residents that the potential to be affected by this deficient practice has had their blosugars assessed. Element#3: To prevent this from happening again, nurses were ins	ncerns nat had nood	
	5/3/18, indicated R cognition. The MDs required extensive transfers, dressing and eating. The MI did not have a swainsulin injections of the assessment per R18's Order Revie physician on 5/11/1 R18's blood sugar. The Facility's Standirected to notify the	nimum Data Set (MDS) dated 18 had severely impaired 5 further indicated R18 assistance with bed mobility, toilet use, personal hygiene, DS indicated R18 did not walk, llowing disorder, and received a seven of seven days during		thru shift report starting 6/21/2018 review the following policies: 1)Chresident's condition or status 2)Me treatment orders 3)Acute conditional changes - clinical protocol. In "Frie Notes" (which is a weekly update regarding facility information that are required to read)on 6/22/2018 stated to nurses to review the abopolicies also. On 7/2/2018 a nurse meeting was held and nurses aga educated on the above policies are facility standing orders with special attention brought to the diabetes puthe standing orders.  Element #4: To maintain compliant F580 the nurse manger, DON or will review all residents with blood monitoring weekly x 4weeks, then	ange n edication tion day  all staff it was ove es in were al oart of nce with designee glucose	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245454	B. WING			1	C <b>21/2018</b>
	PROVIDER OR SUPPLIEI			10	REET ADDRESS, CITY, STATE, ZIP CODE 9 COURT AVENUE SOUTH ANDSTONE, MN 55072		
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F 580	a change in condifurther directed for give 240 milliliters orange juice with half of a sandwich minutes later. For unable to swallow and recheck the bechange in blood siglucose gel. Give minutes in between swallow give Glucintramuscularly (II in 15 minutes. If not the blood sugar complysician immediately in the blood sugar complysician immediately. Signs and tremors, increase nervousness, concoordination, and R18's Medication dated 5/18, indicated R18 had combative with cate offer R18 fluids eaten, and pushed blood sugar was I was present and in the sum of the sum o	tion. The Standing Orders or blood sugars of 60 or below (ml) of 2% milk, skim milk, or graham crackers, cheese or a note of the content of t	F 5	580	2x/month x 3 months and then as basis upon findings. Negative find be reported at the quarterly Qualit meetings. Element #5: The facility will be in compliance with F580 by 7/13/20	lings will ty full	

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	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	•	72 1720 10	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 580	progress note lacked treatments or notific R18's blood sugar I On 6/19/18, at 10:4 representative (F)-/on Mother's Day, R about noon. R18 had and the family had R18 had not been of smelled bad. F-A fluwas low, and R18 h stated R18's blood ambulance. F-A stated R18's blood ambulance. F-A stated low blood sugar On 6/21/18, at 10:4 nurse (LPN)-A stated change, LPN-A wouthe registered nurse the weekend, LPN-supervisor. LPN-A something to drink would monitor. LPN not coherent, she will glucose. LPN-A further standing orders to uthe on call physician On 6/21/18, at 11:1 resident had a charassess the resident was during the weekend-call supervisor. resident had a low standing orders and	ed evidence of assessment, cation of the physician when evels were low.  9 a.m. R18's family awas interviewed, and stated 18's family came to the facility ad been incontinent of stool, to ask for R18 to be changed. dressed or washed, and inther stated R18's blood sugar had to go to the hospital. F-A sugar was 39 in the sted the facility did not catcher, the family did.  43 a.m. licensed practical ed if a resident had a condition ald assess the resident and let be (RN) know. If it was during A would notify the on-call would give the resident food or if they were coherent and then II-A stated If the resident was would give glucose gel or IM ther stated the facility had use, and they were to notify in.  4 a.m. LPN-B stated if a nage in condition, she would it, and let the RN know. If it is kend, LPN-B would notify the LPN-B further stated if a blood sugar, the facility had do she would follow the facility's atted there was a list of on call	F 58				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245454	B. WING				C <b>21/2018</b>
	PROVIDER OR SUPPLIER  ONE HEALTH CARE	CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 09 COURT AVENUE SOUTH ANDSTONE, MN 55072		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	(DON) stated condi- reported by the nursing staff co- managers to see w- afternoon, or on the a supervisor preser the nurses to call he The DON stated nu- physician or call 91: on. The DON stated have to send reside low blood sugar bed facility. The DON st assess their compet during orientation, we there were any issu- one-to-one training, who was working w- sugars were low an hospital, was new to morning medication give R18 some milk had been combative overwhelming for he was re-educated or help from the other calling the physician on one with another the DON would exp the blood sugar, ch assess the resident received Glucagon further stated if those	p.m. the director of nursing tion changes were often sing assistant (NA), during the Stop and Watch forms. Duld call the DON or the RN that they need to do. In the exweekend when there was not not, the DON would encourage ter, or the RN care manager. It is residually the facility does not ents to the hospital due to a cause it is taken care of at the ated staff were evaluated to tencies, skill, and knowledge with on-going training, and if the DON stated the nurse ith R18 the day her blood d she was transported to the to the facility, and it was a busy it pass. The nurse said she did to but did not document it. R18	F	580			

The facility's Nursing Care of the Resident with

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245454	B. WING				C <b>21/2018</b>
	PROVIDER OR SUPPLIER	CENTER		109 C	ET ADDRESS, CITY, STATE, ZIP CODE COURT AVENUE SOUTH DSTONE, MN 55072	1 001	2 1720 10
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F 580	Diabetes Mellitus p severity of hypoglyc combination of bloc symptoms. For resisuch as lethargy arimmediately give ar glucose (four ounce of soda.) Recheck If indicated repeat the sugar in 15 minutes physician.  The facility's Chang Status policy dated would promptly not physician and a rep	olicy dated 12/15, directed the cemia was determined by a signar results and clinical dents who are symptomatic and drowsy and able to swallow, a oral form of rapidly absorbed as of juice or five to six ounces the blood sugar in 15 minutes. The juice and recheck the blood is. If no improvement notify the ge in a Resident's Condition or 12/16, directed the facility ify the resident, the attending presentative of changes in the or mental condition and or		80			
	indicated R25's dia mellitus (DM) type 2 neurological complidisease, and atheron R25's admission M R25 was cognitively R25's care plan date to have blood sugar directed staff to observe symptoms of hyper sugars) or hypoglyce	ted 5/11/18, indicated R25 was r checks as ordered, and serve and report any signs and glycemia (elevated blood					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245454	B. WING		06/21/2018		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 580	included orders for suspension (fast-a insulin for diabetes (tissue under the subcutaneously or subcutaneously in R25's Admission F6/4/18, indicated Fhad been in the 20 physician docume and insulin was be R25's Physician OR25 had an order four times daily wit directed to update blood sugar was lessed to notify the Nglucose result wer 400 in a 24-hour plf no condition chaday.  R25's blood sugar 6/14/18, at 11:00 6/15/18, at 7:48 a.	r Novolog mix 70/30 acting and intermediate-acting so 100 units subcutaneously skin) one time daily, 80 units the time daily, and 100 units the morning.  distory and Physical dated 825's blood glucose readings 90s but were decreasing. The ented R25 had hyperglycemia, sing adjusted.  rders dated 6/4/18, indicated to self check blood glucose the nursing staff. The orders the nurse practitioner (NP) if east than 75 or greater than 300.  Inders dated 6/7/18, directed 1P or physician if two blood to less than 70 or greater than eriod and/or condition change. In the next business single swere as follows:  p.m. 385 m. 319 m. 449, and re-check at 11:44 m. 329 m. 329 m. 393 m. 419 m. 522 m. 391 m. 486 m. 362	F 580				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		LE CONSTRUCTION	COMPLETED		
		245454	B. WING				C <b>21/2018</b>
	PROVIDER OR SUPPLIER	CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	1 0011	2172010
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F 580	Continued From pa 6/18/18, at 12:10 p. 6/18/18, at 4:02 p.n 6/19/18, at 7:44 p.n R25 had several re occurrences of at le 24 hours.  R25's progress note R25 had an order for times daily with NP if blood sugar is 300.  R25's progress note indicated R25's blook had eaten 3 puddin the nurse would foll R25's progress note p.m. indicated R25' time.  R25's progress note notification of the plof R25's elevated be documentation of a	ige 18 im. 451 in. 356 in. 361  adings over 300, and had east 2 readings over 400 within es dated 6/15/18, indicated or self check blood glucose in nursing staff, and update the sless than 75 or greater than es dated 6/16/18, at 9:26 p.m. od sugar was 522, resident gs and an ice cream bar, and low up on the blood sugar.  es dated 6/16/18, at 10:40 is blood sugar was 391 at that es lacked documentation of hysician or nurse practitioner	F 5		DEFICIENCY)		
	would expect nursing sugars, and notify the physician orders and stated the nurse shadocument if the resumptoms with blood parameter. The DC documentation or in	2 p.m. the DON stated she ng to document elevated blood he physician according to the nd parameters. The DON ould do an assessment, and ident was experiencing any od sugars outside the DN verified there was no ndication if the physician or NP 's elevated blood sugars.					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			C (X3) DATE SURVEY		
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	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	1 00/			
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F 582 SS=D			F 58	32		7/20/18		
	services, including covered under Med facility's per diem ra (i) Where changes and services cover. Medicaid State plan notice to residents reasonably possible (ii) Where changes items and services facility must inform 60 days prior to imp (iii) If a resident die transferred and dog facility must refund	in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is						

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NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	· · · · · · · · · · · · · · · · · · ·		
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F 582	per diem rate, for tresided or reserver facility, regardless discharge notice re (iv) The facility mu resident represent the resident within date of discharge f (v) The terms of an behalf of an individual facility must not conthese regulations. This REQUIREME by:  Based on interview facility failed to ensure Advanced Beneficiaresidents (R15, R3 ended, and they residents (R15) Beneficiary completed by the findings include:  R15's form CMS-2 [SNF] Beneficiary completed by the findings include:  R15's form CMS-2 [SNF] Beneficiary form indicated the discharge from when benefit days remained in the face record review reversidents (R123 Notice (NOMNC) howeversidents).	already paid, less the facility's he days the resident actually d or retained a bed in the of any minimum stay or equirements. st refund to the resident or ative any and all refunds due 30 days from the resident's	F 582	To prevent this from happening again social worker was educated to use th following forms (CMS 10123-NOMNO SNFABN) as appropriate. Social work has reviewed back to April 1st 2018 to check on all residents that had the potential to be affected by this deficie practice.  To Maintain compliance with F582 the social worker or designee will complet the required forms as per state/federa requirements. After obtaining the sign notices the social worker or designee make a copy of signed notices and ket these notices in a binder to reference DON or designee will audit the binder weekly x 4 weeks, then monthly x 3 months and then as need basis upon findings. Negative findings will be repat the quarterly Quality meetings Facility will be in full compliance with as of 7/13/2018	ee C & Ker oo ent ee		

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		245454	B. WING			21/2018
NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072	, ,	
(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 APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 582	12/27/17, and the laservice was 1/29/18 "Facility/provider in Medicare Part A se not exhausted." R3 1/29/18. Further refacility had no docu CMS-10123 NOMN Form CMS-10055)  On 6/19/18, at 11:3 worker (SW)-A state notices needed to be remembered giving R33, but could not this had occurred. The facility Resider provided a brief over but does not identification.	dicare Part A services started ast covered day of Part A B. The form indicated the itiated the discharge from rvices when benefit days were 3 remained in the facility after cord review revealed the imentation that it provided IC. In addition, SNF ABN was not provided.  6 a.m. the facility social ed she did not know that two be given. The SW stated she if the CMS-10123 NOMNC to find documentation showing The SW confirmed she had ABN CMS-10055 to either R15 not know of this requirement.	F 583	2		
F 585 SS=D		on of Medicare Beneficiary sted but not received from the 1)-(4)	F 58:	5		7/13/18
	grievances to the fathat hears grievance reprisal and without	ces. esident has the right to voice acility or other agency or entity es without discrimination or t fear of discrimination or vances include those with				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		245454	B. WING _			21/2018
NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072	,	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 585	respect to care and furnished as well are furnished, the behave residents, and other facility stay.  §483.10(j)(2) The resolve grievances accordance with the season of the resident.  §483.10(j)(3) The feat on how to file a griet to the resident.  §483.10(j)(4) The feat grievance policy to of all grievances recontained in this paragraph of the resident. The include:  (i) Notifying resider postings in promine facility of the right to the meaning spoken) grievances anonymof the grievance of can be filed, that is address (mailing an number; a reason accompleting the revit to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvements.	If treatment which has been as that which has not been avior of staff and of other er concerns regarding their LTC esident has the right to and the prompt efforts by the facility to the resident may have, in	F 58	95		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 109 COURT AVENUE SOUTH SANDSTONE, MN 55072			
(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 CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 585	(ii) Identifying a Gresponsible for overeceiving and track conclusions; leading by the facility; main information associexample, the identify grievances submit written grievances submit written grievance coordinating with snecessary in light (iii) As necessary, prevent further porright while the alle investigated; (iv) Consistent with reporting all allege abuse, including in and/or misapproprianyone furnishing provider, to the adas required by State (v) Ensuring that a include the date the summary of the peregarding the residus to whether the confirmed, any contaken by the facility and the date the wear (vi) Taking appropriate appropriate or if an outside entity of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the state of the residents' rigor if an outside entity in the residents' rigor if an outside entity in the re	tion and advocacy system; ievance Official who is erseeing the grievance process, king grievances through to their and any necessary investigations attaining the confidentiality of all atted with grievances, for atty of the resident for those atted anonymously, issuing decisions to the resident; and state and federal agencies as of specific allegations; taking immediate action to tential violations of any resident ged violation is being a §483.12(c)(1), immediately diviolations involving neglect, and injuries of unknown source, interest of the provider; and involved in services on behalf of the ministrator of the provider; and	F 5	85			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
245454		B. WING		C <b>06/21/2018</b>	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SANDSTONE HEALTH CARE	CENTED		109 COURT AVENUE SOUTH		
SANDSTONE HEALTH CARE	CENTER		SANDSTONE, MN 55072		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINT DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
confirms a violation rights within its area (vii) Maintaining expresult of all grievar 3 years from the is decision.  This REQUIREME by: Based on intervier facility failed to engregarding missing up on and address reviewed for grievar Findings include:  R34's Admission Findicated R34's diacognitive impairmed R34's quarterly Min 6/10/18, indicated understood others  R34's significant or indicated it was verthings safe.  R34's care plan in as a vulnerable and and exploitation. Frequired assistance on 6/18/18, at 6:39 been missing a brathe facility had told.	cal law enforcement agency in for any of these residents' as of responsibility; and vidence demonstrating the inces for a period of no less than issuance of the grievance.  ENT is not met as evidenced w and document review, the sure a resident's grievance personal property was followed sed for 1 of 2 residents (R34) ances.  Record printed 6/21/18, agnoses included a mild	F 5	Element #1: R34's grievance was followed up by social worker and bras were purchased so that rescould try them on and find a cornone.  Element #2: Currently there are residents with grievance's out. Element #3: To prevent this from happening again social worker weducated on timely follow-up for grievances. All staff were remind using the grievance forms in "Fri Notes" on 6/22/2018 including us for missing items and assisting ror family members on filling ther Nurses meeting on 7/2/2018 a reabout using the grievance forms again given.  Element #4: To maintain complia F585 all grievances are now bro daily IDT report to discuss and to timely resolution on. DON or desaudit the grievance book weekly weeks, then monthly X 3 months as need basis upon findings. Ne findings will be reported at the quality meetings.  Element #5: Facility will be in full compliance with F585 as of 7/13	multiple ident ect fitting no other was led on day se of form esidents nout. At eminder was once with ught to o seek a signee will X 4 and then gative uarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245454	B. WING _		06	C / <b>21/2018</b>	
NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		72172010	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 585	On 6/19/18, at 3:42 stated she was aw stated they looked it.  On 6/20/18, at 11:5 usually fills out a comissing item form, she was unable to regarding her miss would interview R3 stated they had che SW-A stated they uresult. SW-A verifie form pertaining to I stated they might in SW-A stated she will determine if she had R34 had not stayed facility, so the braid facility.  On 6/21/18, at 10:5	age 25 2 p.m. social worker (SW)-A are of R34's missing bra, and for it, but were unable to locate 63 a.m. SW-A stated the facility oncern grievance form, or and follow up that way, but find one for R34's concern ing bra. SW-A stated she 4 that day and follow-up. SW-A ecked other resident rooms. usually tell the resident the ed she did not find a grievance R34's missing bra. SW-A eplace it if it had been stolen. yould check with R34 to ad any other bras. SW-A stated d out overnight outside of the would have been lost at the	F 58	35			
	station doing puzzl R34 did not have a few staff stopped be was taken to her roassistant (NA)-A. I any bras and said was the only bras shoot have any bras one had talked to hera.  On 6/21/18, at 11:0 uncomfortable with embarrassed some	es, and watching television. I bra on under her shirt, and a by to interact with her. R34 bom per her request by nursing R34 stated she did not have the bra she bought and lost he had. NA-A verified R34 did at that time. R34 stated no her this week about her missing 08 a.m. R34 stated she felt					

AND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  ING	COMPLETED	
		245454	B. WING			C <b>21/2018</b>
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072	1 00/	21/2010
(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 APPROFILITION  DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 585	bought the bra whe Christmas.  The facility policy G the facility to provid of the complaint and soon as possible to	ge 26 e took her bra. R34 stated she n it was cold outside, before rievances dated 5/17, directed e a written notice of resolution d provide it upon request as the complainant after the ed, and within 30 days.	F 5	85		
	Reporting of Alleger CFR(s): 483.12(c) (1) §483.12(c) In response neglect, exploitation must: §483.12(c)(1) Ensure involving abuse, nemistreatment, include source and misappeare reported immediate hours after the allegest that cause the alleges rious bodily injury the events that cause and do not rethe administrator of officials (including the adult protective senfor jurisdiction in lor accordance with Staprocedures. §483.12(c)(4) Repositive staget and the senformatic s	d Violations 1)(4)  Inse to allegations of abuse, In, or mistreatment, the facility  Inse that all alleged violations glect, exploitation or ding injuries of unknown repriation of resident property, liately, but not later than 2 gation is made, if the events ation involve abuse or result in a contract of the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established	F6	09		7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245454	B. WING			C <b>21/2018</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	21/2010	
				109 COURT AVENUE SOUTH			
SANDST	ONE HEALTH CARE	CENTER		SANDSTONE, MN 55072			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 609		alleged violation is verified	F 6	09			
	This REQUIREME by: Based on interview	tive action must be taken.  ENT is not met as evidenced  w and document review, the		All residents of the facility h			
	immediately report 4 residents (R33, I	sure allegations of abuse were ted to the State Agency for 3 of R28, R12) reviewed for abuse.		potential to be affected by t To prevent this from happer staff were re-educated via on 6/22/2018 about timely r	ning again, all 'Friday Notes" reporting, also		
	indicated R33's dia	Record printed 6/21/18, agnoses included history of (stroke) without residual		on 7/2/2018 at nurses mee were re-educated on timely reporting. A new form was i incidents for OHFC reportir includes the time of inciden reported to administrator, D To maintain compliance wit	r abuse made to track ng that now it and times OON & OHFC.		
	6/8/18, indicated F required limited to activities of daily limited			will ensure that all alleged winvolving abuse, neglect, exmistreatment, including injured unknown source and misagresident property, are reported.	xploitation or uries of opropriation of ted		
	a vulnerable adult, abuse or the poter reported per the fa	ated 2/1/18, indicated R33 was and any situation identified as atial for abuse would be acility protocol, and indicated f R33's vulnerability.		immediately but not later the after the allegation is made that cause the allegation in result in serious bodily injur then 24hrs if the events tha allegation do not involve ab	e, if the events volve abuse or by or not later at cause the		
	and stated a fema too tight and it hur identified staff mer	0 p.m. R33 was interviewed le staff had pulled up his pants t. R33 stated he had told the mber that it hurt, and had staff. R33 stated he felt it was		result in serious bodily injur administrator or designee a Administrator or designee we reports with the new form consure that the facility has reprequired. Social Worker or audit the form 2x/week x 4	and OHFC. will track all VA created to make corted timely as designee will		
	R33 was reported (DON).	5 p.m. the incident regarding to the director of nursing dicated the incident was		3x/monthly x 2 months and basis upon findings.Negative be reported at the quarterly meetings.  The facility is in full compliant.	ve findings will quality		

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	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		12112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 609	submitted to the Sta 3:34 p.m.  On 6/19/18, at 4:11 (DON) was intervier notified the administ of abuse immediate to keep R33 safe, a concerns that morn facility goes by the reported to the SA. was no serious injuit. The identified sta and was not workin time.  On 6/19/18, at 4:58 reporting guidelines needed to be reported to the reported to the reported per facility was a vulnerable acidentified as abuse reported per facility R28's progress note indicated another rewhile she sat in a dhallway. The other shoulder and pulled her to, "Get up out confused, and asked	p.m. the director of nursing wed and stated she had trator about R33's allegations ely, implemented interventions and talked to R33 about his ing. The DON stated the resident's perception, so it was The DON stated since there ry, they had 24 hours to report off member was re-educated, g with the resident at that  p.m. the DON reviewed the stated within 2 hours.  ecord printed 6/21/18, gnoses included Alzheimer's elitia.  istated 12/28/17, indicated R28 dult, and any situation or potential abuse would be	F 60	as of 7/10/2018		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245454	B. WING _		1	C <b>21/2018</b>
	NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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) COMPLETION DATE
F 609	R28's allegation of SA on 5/14/18 at 5: after the alleged ab R12's Admission Rindicated R12's dia R12's care plan init had a cognitive impedirected staff to prohygiene, toilet use a An incident dated 3 R12 was found with chest with a sheet than dried feces on sheets. A report for the SA on 4/4/18, a after the alleged ab On 6/21/18, at 4:27 allegations of abuse	abuse was submitted to the 13 p.m. more than 9 hours buse.  ecord printed 6/21/18, gnoses included dementia.  iated 4/6/18, indicated R12 pairment. R12's care plan ovide assistance with personal and incontinent cares.  i/30/18, at 10:30 p.m. indicated in his arms crossed over his cucked around his upper body, his hands, gown, legs, and in this incident was submitted to the 10:16 a.m. more than 5 days buse occurred.  if p.m. the DON verified the evere reported late to the SA.	F 60	9		
F 623 SS=D	Vulnerable Adult Redefined abuse as a unreasonable confipunishment with remental anguish. The to report suspected administrator and SNotice Requirement CFR(s): 483.15(c)(3) Notice Before a facility trainersident, the facility	ats Before Transfer/Discharge 3)-(6)(8) te before transfer. asfers or discharges a	F 62	23		7/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	COM	(X3) DATE SURVEY COMPLETED	
		245454	B. WING _			C / <b>21/2018</b>	
	NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 109 COURT AVENUE SOUTH SANDSTONE, MN 55072			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	the reasons for the language and manifacility must send a representative of the Long-Term Care Of (ii) Record the reast discharge in the rest accordance with paragraph (c)(5) of \$483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transferring (ii) Notice must be before transfer or (A) The safety of in be endangered und this section; (B) The health of in be endangered, un this section; (C) The resident's hallow a more immedunder paragraph (c) (D) An immediate to the required by the resident has redays.  §483.15(c)(5) Continued in the language of the l	f the transfer or discharge and move in writing and in a ner they understand. The copy of the notice to a see Office of the State mbudsman. Sons for the transfer or sident's medical record in aragraph (c)(2) of this section; otice the items described in this section.  In g of the notice. The idea of transfer or under this section must be at least 30 days before the red or discharged. In made as soon as practicable	F 62	3			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED
		245454	B. WING_			C / <b>21/2018</b>
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F 623	must include the for (ii) The reason for (iii) The effective da (iii) The location to transferred or disch (iv) A statement of including the name and telephone num receives such requite to obtain an appear completing the form hearing request; (v) The name, additelephone number Long-Term Care O (vi) For nursing fact and developmental disabilities, the matelephone number the protection and developmental disabilities, the matelephone n	Interest of transfer or discharge; which the resident is narged; the resident's appeal rights, and address (mailing and email), aber of the entity which rests; and information on how a form and assistance in an and submitting the appeal ress (mailing and email) and of the Office of the State mbudsman; illity residents with intellectual address and of the agency responsible for advocacy of individuals with abilities established under Part ental Disabilities Assistance act of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the effor the protection and telephone number of the effor the protection and the Protection and advocacy viduals Act.  Inges to the notice.  In the notice changes prior to the or or discharge, the facility cipients of the notice as soon as the updated information	F 62	23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245454	B. WING		C <b>06/21/2018</b>	
	NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	In the case of facili the administrator of written notification to the State Survey State Long-Term Countries the facility, and the well as the plan for relocation of the re 483.70(I).  This REQUIREME by:	ce in advance of facility closure ty closure, the individual who is f the facility must provide prior to the impending closure Agency, the Office of the care Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at §	F 623			
	facility failed to ensombudsman receind discharge to the horough (R139) reviewed for Findings include:  R139's Admission indicated R139's diheart failure, gastrofibrillation (irregular R139's quarterly M dated 5/7/18, indicated 5/7/18, indicated 5/7/18, indicated 5/7/18, following a R139's progress not the Ombudsman with hospitalization.	w and document review, the sure the Long Term Care ved written notification of ospital for 1 of 1 residents or hospitalization.  Record printed 6/19/18, iagnoses included congestive ointestinal hemorrhage, atrial repeat beat), and dementia.  inimum Data Set assessment ated R139 had been turn anticipated on 5/7/18.  otes dated 5/7/18, indicated he hospital and hospitalized on sudden change in condition. otes lacked documentation that was notified regarding R139's		Social worker updated ombudsma written communication on 7/13/201 regarding (R139) discharge to hosp All residents of the facility have the potential to be affected by this violated Social worker went back to April 1st and updated ombudsman's via writt communication any resident that wis missed for notification.  To prevent this from happening agasocial worker was educated on not the ombudsman with written notification transfers/discharges as required.  To maintain compliance with F623 social worker or designee will notification transfers/discharges on a weekly be DON or designee will audit this weekes, then monthly x 3 months are as need basis upon findings. Negating findings will be reported at the quality meetings.  The facility will be in full compliance F623 as of 7/13/2018	8 bital.  ation. t, 2018 ten as ain, ifying ation of the y the asis. ekly x 4 and than tive terly	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	COMPLETED	
		245454	B. WING		C 06/21/2018	
	PROVIDER OR SUPPLIER  ONE HEALTH CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	1 0011	172010
(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 CROSS-REFERENCED TO THE APPROPOLICIENCY)	) BE	(X5) COMPLETION DATE
	Continued From particles of the horizontal discharge to the horizon of the horizo	ge 33  p.m. the Ombudsman verified did not get notified of R139's spital, or subsequent death.  p.m. social worker (SW)-A totify the Ombudsman of and stated she though she che ombudsman a voice R139's discharge.  p.m. SW-A verified she did adsman regarding R139's -A stated they did not have a nof the Ombudsman of a stated she should follow the not Revision (2)(i)-(iii)  Shensive Care Plans apprehensive care plan must a 7 days after completion of assessment.  Interdisciplinary team, that imited to hysician.  The with responsibility for the service of the completion of the completion.		CROSS-REFERENCED TO THE APPROP DEFICIENCY)  23		
	resident. (D) A member of fo (E) To the extent pr the resident and the An explanation mus medical record if the	th responsibility for the od and nutrition services staff. acticable, the participation of e resident's representative(s). It be included in a resident's e participation of the resident epresentative is determined				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245454	B. WING _		1	21/2018	
	NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 657	not practicable for resident's care plan (F) Other appropria disciplines as dete or as requested by (iii)Reviewed and ream after each as comprehensive an assessments. This REQUIREME by:  Based on observareview, the facility was revised to reflet of 1 residents (Rulcers.  Findings include:  R3's Admission ReR3 was admitted or revealed R3's diag without behavioral and hypertension.  R3's quarterly Mini 4/2/18, indicated R impairment.  R3 care plan dated has potential impairment MAS damage] noted to i resolved on 3/28/16/18/18, indicated, healed by the reviewed.	the development of the n. ate staff or professionals in rmined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the	F 65	Element #1: Resident R3's care updated on 6/21/2018 to reflect the pressure ulcer Element#2: All residents of the fathe potential to be affected by the violation. All residents care plans reviewed to make sure they are a updated. Element #3: To prevent this from happening again, nurse manager coordinator have been educated updated residents plan of care as changes occur. Element #4: To maintain compliant F657 the DON or designee will a care plans monthly x 3 months a as need basis upon findings to eath any revisions that are needed been completed. Negative finding reported at the quarterly quality in Element #5: The facility will be in compliance with F657 as of 7/13/	acility had so will be all so with udit 4 and than a sure d have gs will be neetings. full		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, 109 COURT AVENUE SC SANDSTONE, MN 55	DUTH	00/21/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 657	Calazinc cream (to every shift for pressinght buttock until recovered by the revealed, "During recalled writer to assinght buttock. Area less than 0.1 cm. [6] shiny pink granular healthy, pink and be resolved by the recovered b	ler dated 5/22/18, directed pical moisture barrier cream) sure ulcer. Apply topically to esolved.  dated 5/21/18 at 12:12 p.m. esident shower nurses aide ess an open area on resident measures 1.2 cm x 2.1 cm x Centimeter] The wound bed is tissue, and the peri wound in lanchable"  dated 5/23/18 at 3:47 p.m. measures 1.2 cm x 2.1 cm x 3.2 cm x 2.1 cm x 3.3 cm and the peri wound in healthy, e. Treatment includes includes ar on her right buttock but it is neasures 1.2 cm x 2.1 cm x 3.3 cm and the peri wound in healthy, e. Treatment includes includes ar on her right buttock but it is neasures 1.2 cm x 2.1 cm x 3.3 cm and the peri wound in healthy, e. Treatment includes includes	F 6				
	specified " Area and is a dry, lifted, considered a stage scabbed with a hea wound in healthy, p includes includes of	dated 6/13/18 at 4:12 p.m. measures 0.3 cm x 0.3 cm, dark brown scab. It still two pressure area that is aling wound bed. The perionk and blanchable. Treatment alazinc q shift"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245454		B. WING		06	C 06/21/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		121/2010	
SANDST	ONE HEALTH CARE	CENTER		109 COURT AVENUE SOUTH SANDSTONE, MN 55072			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 657	the pressure ulcer.	ge 36 lan lacked documentation of RN-A stated, "Is my date the care plan, and I	F6	57			
F 726 SS=D	Person-Centered redirected, "13. Asserting and care prinformation about the conditions change."	staff	F 7	26		7/13/18	
	the appropriate corprovide nursing and resident safety and practicable physical well-being of each resident assessme and considering the diagnoses of the fall accordance with the at §483.70(e).  §483.35(a)(3) The licensed nurses had and skill sets necess needs, as identified assessments, and §483.35(a)(4) Provilimited to assessing	ave sufficient nursing staff with inpetencies and skills sets to direlated services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care in number, acuity and cility's resident population in a facility assessment required facility must ensure that we the specific competencies is sary to care for residents' I through resident described in the plan of care. In iding care includes but is not go, evaluating, planning and ent care plans and responding					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		7. 50.251				c	
		245454	B. WING_			21/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
SANDST	ONE HEALTH CARE	CENTER		109 COURT AVENUE SOUTH			
SANDST	ONE REALTH CARE	CENTER		SANDSTONE, MN 55072			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 726	§483.35(c) Proficies The facility must ento demonstrate contechniques necess needs, as identified assessments, and This REQUIREME by: Based on interview facility failed to ensidemonstrated comidentifying changes timely notification of in condition was identifying changes timely notification of in condition.  Findings include:  R18's Admission Rincluded diagnoses dementia and anxious R18's quarterly Mir 5/3/18, indicated R cognition. The MD required extensive transfers, dressing and eating. The MI did not have a swainsulin injections of the assessment per R18's Order Review physician on 5/11/1	ency of nurse aides. Insure that nurse aides are able impetency in skills and ary to care for residents' distributed through resident described in the plan of care.  In and document review, the sure licensed nursing staff petency skills related to in resident condition and of the physician when a change entified for 1 of 2 residents notification of change in  Ecord printed 6/21/18, sof type two diabetes, ety.  Inimum Data Set (MDS) dated 18 had severely impaired 5 further indicated R18 assistance with bed mobility, toilet use, personal hygiene, DS indicated R18 did not walk, llowing disorder, and received in seven of seven days during	F 72	Element #1: The nurse that appropriately assess and upfamily with condition change R18 has been terminated as Element #2: All other resider facility had the potential to be the violation.  Element #3: To prevent this happening again, nurses we thru shift report starting on 6 review the following 3 polices in resident's condition or stat 2)Medication & treatment or condition changes - clinical p6/22/2018 in "Friday Notes" if for nurses to review the above also. On 7/2/2018 a nurses rheld, and nurses again were the above polices.  Element #4: To maintain con F726 the DON or designee were sidents weekly x 4 weeks a residents monthly x 3 month change in condition has not lalong with updating MD/NP and Negative findings will be reported to the property Quality meetings Element #5: The facility will be	date MD & for resident of 6/21/2018 hts of the e affected by from re instructed /21/2018 to s: 1)Change us ders 3) Acute protocol. On t was stated re policies meeting was educated on appliance with vill audit 2 and then 4 s to ensure a been missed and family. brited at the		
		ding orders signed 6/7/18, e physician if two blood sugar		compliance with F726 as of	7 10/2010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	245454		B. WING		0.0	C 00/24/2048	
NAME OF	PROVIDER OR SUPPLIER		D: Willo	STREET ADDRESS, CITY, STATE, ZIP COI		5/21/2018	
	ONE HEALTH CARE			109 COURT AVENUE SOUTH SANDSTONE, MN 55072			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 726	results are less that a change in condit further directed for give 240 milliliters orange juice with ghalf of a sandwich minutes later. For unable to swallow; and recheck the bichange in blood suglucose gel. Give minutes in betwee swallow give Gluca intramuscularly (IN in 15 minutes. If not the blood sugar cophysician immedial R18's care plan reclinical monitoring directed to observe signs or symptoms sugar). Signs and tremors, increased nervousness, conficoordination, and stated 5/18, indicated R18's blood sugar R18's progress no indicated R18 had combative with car to offer R18 fluids eaten, and pushed blood sugar was less that the summer of the summ	an 70 in a 24 hour period and/or ion. The Standing Orders blood sugars of 60 or below (ml) of 2% milk, skim milk, or graham crackers, cheese or a Repeat blood sugar check 30 blood sugars of 50 and below if give one tube of glucose gelood sugar in 15 minutes. If no ugar give another tube of up to 3 tubes waiting 15 n. If the resident was unable to agon (glucose) 1 milligram (mg) 1) and recheck the blood sugar or increase in the blood sugar or intinues to drop, contact the tely.  Wised on 4/14/18, indicated for diabetes. Interventions and report as needed any of hypoglycemia (low blood symptoms included sweating, I heart rate, pallor, usion, slurred speech, lack of staggered gait.  Administration Record (MAR) ed on 5/13/18, at 8:00 a.m. was 50, and at 12:00 p.m.	F 7	26			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245454	B. WING _		0	C 6/ <b>21/2018</b>
	NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	•	5/Z 1/Z0 10
(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 APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 726	hospital. R18 was to progress note lacked treatments or notifice R18's blood sugar. On 6/19/18, at 10:4 representative (F)-to on Mother's Day, Rabout noon. R18 had not been of smelled bad. F-A for was low, and R18 had not been of smelled bad. F-A for was low, and R18 had not been of smelled bad. F-A for was low, and R18 had not been of smelled bad. F-A for was low, and R18 had not been of smelled bad. F-A for was low, and R18 had not been of smelled bad. F-A for was low, and R18 had not been of smelled bad. F-A for was low, and R18 had not blood sugar. The nursing staff of managers to see was afternoon, or on the a supervisor present he nurses to call how blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility. The DON state have to send reside low blood sugar be facility and state have to send reside low blood sugar be facility.	then sent to the hospital. The ed evidence of assessment, cation of the physician when levels were low.  19 a.m. R18's family A was interviewed, and stated tals's family came to the facility ad been incontinent of stool, to ask for R18 to be changed. It is a continent of stool, the stated R18's blood sugar that to go to the hospital. F-A sugar was 39 in the lated the facility did not catch		26		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245454	B. WING			C <b>06/21/2018</b>	
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 109 COURT AVENUE SOUTH SANDSTONE, MN 55072	•	72172010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	give R18 some milk had been combative overwhelming for he was re-educated or help from the other calling the physician on one with another the DON would expethe blood sugar, chassess the resident received Glucagon. The facility's Nurse indicated the nurse updating the provide the rounding folder. The facility's Chang Status policy dated would promptly noting physician and a represident's medical of status.  Food Procurement, CFR(s): 483.60(i) (1) \$483.60(i) Food sate The facility must - \$483.60(i)(1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility must - \$483.60(i) (1) - Procurement of the facility mu	in pass. The nurse said she did it, but did not document it. R18 are earlier and it was er. The DON stated the nurse in standing orders, asking for nurse, calling the DON and in. The also nurse worked one in nurse. Since R18 was alert, sect staff to give milk, recheck eck the standing orders and its condition. R18 could have per standing orders.  Orientation documentation received orientation on ers by telephone, facsimile or a Resident's Condition or 12/16, indicated the facility fy the resident, the attending resentative of changes in the or mental condition and or store/Prepare/Serve-Sanitary (2)  Store/Prepare/Serve-Sanitary (2)  Sety requirements.	F 72			7/13/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245454	B. WING		C 06/21/2018		
	PROVIDER OR SUPPLIER	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072				
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	safe growing and for (iii) This provision of from consuming for serve food in according standards for food at This REQUIREMENDY:  Based on observed review, the facility for were dated when the R5, R3, R32, R8, Rough received supplements and instructions not after being thawed. Confirmed findings, aware of the instructions not after being thawed. Confirmed findings, aware of the instructions not after being thawed. Confirmed findings, aware of the instructions not after being thawed. The Lyons Readyca undated, under she good for no more the serve food in the context of t	compliance with applicable pod-handling practices. loes not preclude residents ods not procured by the facility.  The prepare, distribute and dance with professional service safety.  The is not met as evidenced sion, interview, and document ailed to ensure supplements hawed for 8 of 8 residents (R7, 16, R30, and R20) who onts.  The seven chocolate and y Shake supplement cartons ated and thawed in the nain dining room. The cartons at to serve more than 14 days. The dietary manager (DM). The DM reported she was not etions on the package. The reported she stocked the was not aware of how long are Nutritional Product Line	F 812	Element #1: All mighty shakes were thrown out that were not dated in the fridge.  Element #2: All resident who are on to have nutritional supplements have potential to be affected by the violate Element #3: To prevent this from happening again, the dietary manateducated dietary staff on proper for storage and labeling information all with a copy of the policy and procee Element #4: To maintain compliant F812 the dietary manger or designated the dietary manger or designated food storage & labeling week weeks, then 3x/month x 2 months then monthly thereafter. Negative fixed will be reported at the quarterly Quimeetings.  Element #5: The facility will be in fuccompliance with F812 as of 7/13/26	rdered d the tion.  ger od ong dure. ce with ee will ly x 4 and indings ality  Ill 018		
	Infection Prevention CFR(s): 483.80(a)(		F 880		•	7/13/18	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
	245454		B. WING			C <b>06/21/2018</b>	
	NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		72 1720 10	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	infection prevention designed to provide comfortable enviror development and to diseases and infection program.  The facility must est and control program a minimum, the followed to providing services arrangement based conducted according accepted national services for the but are not limited to (i) A system of surverpossible communications before the persons in the facility when and to who communicable diserported; (iii) Standard and to be followed to providing to providing to be followed to provide	control ctablish and maintain an and control program a a safe, sanitary and ment and to help prevent the cansmission of communicable ctions. In prevention and control ctablish an infection prevention in (IPCP) that must include, at owing elements:  Stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ing to §483.70(e) and following standards; en standards, policies, and program, which must include, io: eillance designed to identify cable diseases or ey can spread to other ity; iom possible incidents of case or infections should be cansmission-based precautions event spread of infections; isolation should be used for a	F 88				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
	245454		B. WING			C <b>06/21/2018</b>	
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 COURT AVENUE SOUTH SANDSTONE, MN 55072		172010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	involved, and (B) A requirement to least restrictive post circumstances. (v) The circumstant must prohibit employing disease or infected contact with reside contact will transmit (vi)The hand hygies by staff involved in \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must has transport linens so infection.  \$483.80(f) Annual of the facility will confident facility will confident facility will confident facility will confident facility for the facility for the facility of the facility for the facility of the facility for the facility of the Legionella policity guidance for managed	that the isolation should be the sible for the resident under the ces under which the facility byces with a communicable skin lesions from direct ints or their food, if direct if the disease; and the procedures to be followed direct resident contact.  Stem for recording incidents a facility's IPCP and the taken by the facility.  Indle, store, process, and as to prevent the spread of	F 88	Element #1: Resident R25 wa own glucometer to keep in his 6/21/2018. Element #2: All other diabetic r who receive glucometer check potential to be affected by the Element #3: To prevent this fro happening again the blood glucopolicy & procedure was update nurses were educated on it at the second support of the procedure was update of the procedure was updated to the pr	room on residents s had the violation. om cometer ed and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245454	B. WING _			C 06/21/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
SANDST	ONE HEALTH CARE	CENTER		109 COURT AVENUE SOUTH SANDSTONE, MN 55072			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Findings include:  R25's Admission Findicated R25's diamellitus type 2, an methicillin resistant (MRSA).  R25's admission M5/10/18, indicated had a surgical would had a surgical would resist and to do glucometer of R25's progress not o self check blood nursing staff.  R25's Physician O	Record printed 6/21/18, agnoses included diabetes d R25 was a carrier of at staphylococcus aureus  Minimum Data Set (MDS) dated R25 was cognitively intact, and and.  Itiated 5/11/18, directed nursing checks as ordered.  Ites indicated R25 had an order d glucose four times daily with	F 8		procedure was Surveillance and for this will go / 13th for staff to y. The ment policy was compliance with DON or es monthly x 3 s upon findings Glucometer use ngs will be Quality meetings. ill be in full		
	On 6/18/18, at 3:5 entered R25's roomer precautions for MF her hands, and ha own blood glucose glucometer. R25 of finger with the land sample. R25 place that had been place removed the test send the insulin, injected glucometer up from removed her glove carried the glucomedical properties.	daily and at bedtime.  3 p.m. registered nurse (RN)-B m. R25 was on contact RSA in a wound. RN-B sanitized nded R25 the supplies to do his e check with the facility cleansed his finger, poked his bet, and obtained his blood ed the sample onto the test strip ded in the glucometer, and strip after reading the result. Insed the site for the injection of d the insulin, and picked the m R25's tray table. RN-B es, sanitized her hands, and meter in her left hand. RN-B ation cart with her right hand, meter directly on the medication					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COM	(X3) DATE SURVEY COMPLETED C	
		245454	B. WING			06/21/2018	
	PROVIDER OR SUPPLIER			109 COU	ADDRESS, CITY, STATE, ZIP CODE IRT AVENUE SOUTH TONE, MN 55072	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	cart. RN-B then gl Sani-wipe, cleans it in a purple Sani-RN-B stated the g glucometer, and v precautions. RN-E glucometer, and s directly on the methere was a risk for stated she should before setting it or then wiped off the Sani-wipe.  On 6/21/18, at 3:4 (DON) verified the contamination with placed on the medithe facility was go R25 his own person to remain undated, super Sani-cloth to glucometer, thorout the treated glucometer to remain wet for a The facility policy undated, lacked g suspected Legionocriteria and paramon On 6/21/18, at 4:0 (DON) verified the management of st DON stated they were sani-cloth the management of st DON stated they were sani-cloth the management of st DON stated they were sani-cloth the management of st DON stated they were sani-cloth the management of st DON stated they were sani-cloth the management of st DON stated they were sani-cloth the management of states and paramon states	oved, opened a purple ed the glucometer and wrapped wipe, and placed it in a cup. Ilucometer was a shared erified R25 was on contact it verified R25 handled the he set the unclean glucometer dication cart. RN-B verified or cross contamination, and have cleansed the glucometer in the medication cart. RN-B medication cart with a purple of p.m. the director of nursing re could be a risk of cross in the unclean glucometer dication cart. The DON stated ing to be looking into getting onal glucometer.  Assure Prism Blood Glucose in Recommended Use and directed nursing to use a clean of clean and disinfect the aughly wet the glucometer, lay meter on paper towel and allow a full 2 minutes and let air dry.  Water Management System uidance for management of ella cases, and lacked testing	F8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION  NG	CON	(X3) DATE SURVEY COMPLETED  C		
245454			B. WING _		I			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPOPULATION OF TH	OULD BE	(X5) COMPLETION DATE		

Printed: 06/28/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245454

B. WING \_

06/20/2018

NAME OF PROVIDER OR SUPPLIER

#### SANDSTONE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### **109 COURT AVENUE SOUTH**

SANDSTONE HEALTH CARE CENTER		SANDSTONE, MN 55072			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)	ULATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS	K 000			
	FIRE SAFETY  A Life Safety Code Survey was conducted	by the			
	Minnesota Department of Public Safety, St Fire Marshal Division. At the time of this s Sandstone Nursing Health Care Center wa found in compliance with the requirements participation in Medicare/Medicaid at 42 Cl Subpart 483.70(a), Life Safety from Fire, a 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Saf Code (LSC), Chapter 19 Existing Health C	urvey as for FR, and the			
	Sandstone Nursing Health Care Center, is 1-story building with a partial basement. The original building was constructed in 1963 a determined to be of Type II(111) constructing 1988 an addition was constructed to the buthat was determined to be of Type II(111) construction. Because the original building its additions meet the construction type allefor existing buildings, this facility was survey a single building.	he and was ion. In uilding ng and owed			
	The building is fully fire sprinklered protect also has a fire alarm system with smoke detection in the corridors and spaces oper corridors that is monitored for automatic fire department notification.	n to the			
	The facility has a capacity of 45 beds and census of 38 at the time of the survey.	had a		± (	
	The requirement at 42 CFR Subpart 483.7 Met.	70(a) is			
LABORATO	DRY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENT	TATIVE'S SIGNATURE	TITLE	(X6) DATE	

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 5, 2018

Mr. Tom Opatz, Administrator Sandstone Health Care Center 109 Court Avenue South Sandstone, MN 55072

Re: State Nursing Home Licensing Orders - Project Numbers S5454028 and H5454010

Dear Mr. Opatz:

The above facility was surveyed on June 18, 2018 through June 21, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5454010. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

Sandstone Health Care Center July 5, 2018 Page 2

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 immediately contact Teresa Ament, Unit Supervisor at (218) 302-6151 or teresa.ament@state.mn.us.

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,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Jovens S. Lapson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00452	B. WING		C <b>06/21/2018</b>	
	NAME OF PROVIDER OR SUPPLIER  SANDSTONE HEALTH CARE CENTER  STREET A  109 COI SANDS					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber arule contain comply with any of lack of compliance. re-inspection with a	nether a violation has been				
	corrected.	ring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	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				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 07/13/18

TITLE

STATE FORM 6899 If continuation sheet 1 of 29 XO2U11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00452	B. WING		<b>I</b>	C <b>21/2018</b>
	PROVIDER OR SUPPLIER	CENTER 109 COUR	DRESS, CITY, S' RT AVENUE S DNE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "cor text. You must then State licensure procompletion date, th corrected prior to e Minnesota Department's staff the following correction that you and identify the dat H Complaint H545 was substantiated.  Minnesota Department the State Licensing federal software. Ta assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of column entitled "ID statute/rule out of column entitled" in the statement evidence by." Followare the Suggested Time period for Column entitled Time period for Colu	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.  In 6/21/18, surveyors of this visited the above provider and ction orders are issued. Four electronic plan of have reviewed these orders, when they will be completed. 4010 was investigated and the ent of Health is documenting. Correction Orders using ag numbers have been sota state statutes/rules for the opening the interest of Deficiencies" column to Comply" portion of the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis	2 000			
	FOURTH COLUMN					

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				,			С
		00452		B. WING			21/2018
NAME OF	PROVIDER OR SUPPLIER	ST	REET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	SENTER		RT AVENUE S ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIOI		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2		2 000			
		RAL DEFICIENCIES O R ON EACH PAGE.	NLY.				
	PLAN OF CORREC	QUIREMENT TO SUBMI CTION FOR VIOLATION E STATUTES/RULES.					
2 265	MN Rule 4658.0085 Resident Health Sta	5 Notification of Chg in atus		2 265			7/13/18
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, ar attending physician development of the	st develop and implement of decisions to consult an assistants, and nurse known, notify the residence or an interested family ant's acute illness, serious At a minimum, the direct of the medical director of must be involved in the se policies. The policies address at least the tion times for:	ent's us ctor of or an				
		involving the resident when the potential for recon;					
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, fo ation in health, mental, in either life-threatening l complications;	or or				
	example, a need to	ter treatment significantl discontinue an existing adverse consequences f treatment;	form				
	D. a decision t	o transfer or discharge t	the				

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AND DIAN OF CORRECTION TO TRENTIFICATION NUMBERS					(3) DATE SURVEY COMPLETED	
		00450	B. WING			
		00452	B. WING		06/2	1/2018
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	ONE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	resident from the nu	ursing home; or				
	E. expected an	d unexpected resident deaths.				
	by: Based on interview, facility failed to ensi upon a change in co	and document review, the ure the physician was notified ondition for 2 of 4 residents		Corrected		
	, ,	d for notification of change.				
	Findings include:					
		ecord printed 6/21/18, of type two diabetes, ety.				
	5/3/18, indicated R <sup>2</sup> cognition. The MDS required extensive a transfers, dressing, and eating. The MD did not have a swal	imum Data Set (MDS) dated 18 had severely impaired 5 further indicated R18 assistance with bed mobility, toilet use, personal hygiene, DS indicated R18 did not walk, lowing disorder, and received seven of seven days during riod.				
	physician on 5/11/1	v Report signed by the 8, included orders to check our times a day for diabetes.				
	directed to notify the results are less than a change in condition further directed for give 240 milliliters ( orange juice with gr	ling orders signed 6/7/18, e physician if two blood sugar n 70 in a 24 hour period and/or on. The Standing Orders blood sugars of 60 or below ml) of 2% milk, skim milk, or raham crackers, cheese or a Repeat blood sugar check 30				

Minnesota Department of Health

STATE FORM 6899 XO2U11 If continuation sheet 4 of 29

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.	С		,
		00452	B. WING			1/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE			
	OLIMA DV OTA		NE, MN 550		ION	0.4=)
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	Continued From pa	nge 4	2 265			
	unable to swallow; and recheck the blochange in blood surglucose gel. Give uninutes in between swallow give Gluca intramuscularly (IM in 15 minutes. If not the blood sugar corphysician immediated R18's care plan revolutional monitoring for directed to observe signs or symptoms sugar). Signs and stremors, increased	vised on 4/14/18, indicated for diabetes. Interventions and report as needed any of hypoglycemia (low blood symptoms included sweating, heart rate, pallor, usion, slurred speech, lack of				
	dated 5/18, indicate	administration Record (MAR) ed on 5/13/18, at 8:00 a.m. was 50, and at 12:00 p.m. was 59.				
	indicated R18 had combative with care to offer R18 fluids be eaten, and pushed blood sugar was low was present and rehospital. R18 was to progress note lacked treatments or notific R18's blood sugar	e dated 5/13/18, at 2:45 p.m. been lethargic all day, and was es. Many attempts were made out R18 refused. R18 had not away staff's hands. R18's w in parameter. R18's family equested R18 be sent to the hen sent to the hospital. The ed evidence of assessment, cation of the physician when levels were low.				
		A was interviewed, and stated				

Minnesota Department of Health

STATE FORM 6899 XO2U11 If continuation sheet 5 of 29

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		C		
		00452		B. WING			21/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SANDS	TONE HEALTH CARE	CENTER		RT AVENUE S ONE, MN 550			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 265	Continued From para on Mother's Day, Rabout noon. R18 had not been on smelled bad. F-A for was low, and R18 had not been on smelled bad. F-A for was low, and R18 had not been on smelled bad. F-A for was low, and R18 had a low standing orders to the on call physician on 6/21/18, at 10:10 nurse (LPN)-A something to drink would monitor. LPN not coherent, she was during the weekend, LPN-a something orders to the on call physician on 6/21/18, at 11:11 resident had a charassess the resident was during the week on-call supervisor. resident had a low standing orders and protocol. LPN-B standing orders and p	at 18's family of ad been income to ask for Rodressed or worther stated that the facility of the sugar was 3 at the family of the stated if the family of th	ntinent of stool, 18 to be changed. ashed, and R18's blood sugar the hospital. F-A 9 in the ty did not catch did.  sed practical and had a condition he resident and let are the food or coherent and then the resident was bucose gel or IM he facility had a were to notify. B stated if a the facility had a were to notify the er stated if a the facility had follow the facility had follow the facility's as a list of on call eded.  ector of nursing a were often it (NA), during d Watch forms. DON or the RN d to do. In the	2 265			

Minnesota Department of Health

STATE FORM KO2U11 If continuation sheet 6 of 29

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	<del></del>	COMPLETED	
		00452	B. WING		06/2	2 1/2018
NAME OF I	PROVIDER OR SUPPLIER		DESS CITY S	STATE, ZIP CODE	1 00/2	2010
NAIVIL OI I	-NOVIDEN ON SUFFEIEN		RT AVENUE S			
SANDST	ONE HEALTH CARE	CENTER	NE, MN 550			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 265	Continued From pa	ge 6	2 265			
2 265	a supervisor preser the nurses to call he The DON stated nurses to call he The DON stated nurses to send reside low blood sugar bed facility. The DON stated have to send reside low blood sugar bed facility. The DON states their compeduring orientation, withere were any issurence on the sugars were low an hospital, was new to morning medication give R18 some milk had been combative overwhelming for he was re-educated or help from the other calling the physiciar on one with another the DON would expet the blood sugar, chassess the resident received Glucagon further stated if those done, the outcome different.  The facility's Nursin Diabetes Mellitus poseverity of hypoglyc combination of bloosymptoms. For resident	at, the DON would encourage er, or the RN care manager. rsing staff could also notify the 1, depending what was going d typically the facility does not ents to the hospital due to a cause it is taken care of at the ated staff were evaluated to tencies, skill, and knowledge with on-going training, and if es she would do some. The DON stated the nurse ith R18 the day her blood d she was transported to the or the facility, and it was a busy it pass. The nurse said she did at, but did not document it. R18	2 265			
	immediately give ar glucose (four ounce	n oral form of rapidly absorbed es of juice or five to six ounces the blood sugar in 15 minutes.				

Minnesota Department of Health

STATE FORM 6899 XO2U11 If continuation sheet 7 of 29

AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
						С	
		00452	B. WING		<b>I</b>	21/2018	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE : ONE, MN 550				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
2 265	Continued From pa	ge 7	2 265				
		he juice and recheck the blood s. If no improvement notify the					
	Status policy dated would promptly noti physician and a rep	le in a Resident's Condition or 12/16, directed the facility fy the resident, the attending presentative of changes in the or mental condition and or					
	indicated R25's diag mellitus (DM) type 2 neurological compli	ecord printed 6/21/18, gnoses included diabetes 2 with other diabetic cation, chronic kidney osclerotic heart disease.					
	R25's admission MI R25 was cognitively	DS dated 5/10/18, indicated / intact.					
	to have blood sugar directed staff to obs	red 5/11/18, indicated R25 was r checks as ordered, and serve and report any signs and glycemia (elevated blood semia.					
	included orders for suspension (fast-ac insulin for diabetes) (tissue under the sk	cting and intermediate-acting 100 units subcutaneously kin) one time daily, 80 units time daily, and 100 units					
	6/4/18, indicated R2 had been in the 200	story and Physical dated 25's blood glucose readings 0s but were decreasing. The ted R25 had hyperglycemia, ng adjusted.					

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	-p.   ` `	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
	A. Boilbino.			С	
00452	B. WING			21/2018	
NAME OF PROVIDER OR SUPPLIER ST	TREET ADDRESS, CITY, STA	E, ZIP CODE			
SANDSTONE HEALTH CARE CENTER	09 COURT AVENUE SO ANDSTONE, MN 55072				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
2 265 Continued From page 8	2 265				
R25's Physician Orders dated 6/4/18, indic R25 had an order to self check blood gluco four times daily with nursing staff. The ord directed to update the nurse practitioner (N blood sugar was less than 75 or greater that R25's Standing Orders dated 6/7/18, direct staff to notify the NP or physician if two blooglucose result were less than 70 or greater 400 in a 24-hour period and/or condition change, notify the next busin day.  R25's blood sugars were as follows: 6/14/18, at 11:00 p.m. 385 6/15/18, at 7:48 a.m. 319 6/15/18, at 11:43 a.m. 449, and re-check at a.m. was 449 6/15/18, at 4:25 p.m. 329 6/16/18, at 11:45 a.m. 393 6/16/18, at 11:45 a.m. 393 6/16/18, at 4:29 p.m. 419 6/16/18, at 3:26 p.m. 522 6/16/18, at 10:41 p.m. 391 6/17/18, at 8:53 p.m. 362 6/17/18, at 8:58 p.m. 362 6/17/18, at 4:02 p.m. 486 6/17/18, at 12:10 p.m. 451 6/18/18, at 7:44 p.m. 361  R25 had several readings over 300, and had occurrences of at least 2 readings over 400 24 hours.  R25's progress notes dated 6/15/18, indicated R25 had an order for self check blood gluctour times daily with nursing staff, and upda NP if blood sugar is less than 75 or greater	ated ose ers IP) if an 300. ed od than hange. hess  t 11:44				

Minnesota Department of Health

STATE FORM 6899 XO2U11 If continuation sheet 9 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	A. BUILDING:						
		00452		B. WING			C 21/2018
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER		RT AVENUE S ONE, MN 550			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC <sup>)</sup> REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ige 9		2 265			
	R25's progress not indicated R25's blo had eaten 3 puddir the nurse would fol R25's progress not	od sugar was 5 igs and an ice o low up on the b	522, resident cream bar, and blood sugar.				
	p.m. indicated R25 time.	's blood sugar v	was 391 at that				
	R25's progress not notification of the p of R25's elevated be documentation of a medical status or s	hysician or nur blood sugars an in assessment	se practitioner id of R25's				
	On 6/21/18, at 12:1 would expect nursing sugars, and notify the physician orders are stated the nurse shadocument if the research symptoms with blood parameter. The DO documentation or in was notified of R25	ng to documen the physician action and parameters. It is to all a second and a second and a second augurs outsion of the indication if the	t elevated blood ccording to the The DON essment, and eriencing any ide the e was no physician or NP				
	SUGGESTED MET	THOD FOR CO	RRECTION:				
	The director of nurs review and/or revis ensure residents' p change in condition	e policies and ր hysician was ir	procedures to				
	The DON or design appropriate staff or						
	The DON or design system to ensure o						

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00452	B. WING		06/2	21/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE ONE, MN 55				
(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 SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 265	Continued From pa	ge 10	2 265				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			7/13/18	
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required					
	by: Based on observati review, the facility fa was revised to refle	ent is not met as evidenced on, interview, and document ailed to ensure the care plan oct a current pressure ulcer for Previewed for pressure		Corrected			
	Findings include:						
	R3 was admitted or revealed R3's diagr	cord printed 6/20/18, indicated n 7/10/14. The medical record noses included dementia disturbance, atrial fibrillation					
		num Data Set (MDS) dated 3 had severe cognitive					

6899

Minnesota Department of Health STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			C	
		00452	B. WING		I	21/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE S ONE, MN 550				
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 570	Continued From pa	nge 11	2 570				
	has potential impairelated to fragile simpairment MAS damage] noted to in resolved on 3/28/18/6/18/18, indicated, healed by the revie plan lacked docum pressure ulcer.  R3's Physician Ord Calazinc cream (to every shift for pressinght buttock until response to the control of the control	4/3/18, indicated, " resident rment to skin integrity r/t skin, dementia with cognitive ED [moisture-associated skin intergluteal fold on 3/12/18 and 8." In addition, care plan dated "The resident MASD will be w date" However, the care entation that R3 had a current er dated 5/22/18, directed pical moisture barrier cream) sure ulcer. Apply topically to esolved.  dated 5/21/18 at 12:12 p.m. esident shower nurses aide					
	called writer to assoright buttock. Area less than 0.1 cm. [6	ess an open area on resident measures 1.2 cm x 2.1 cm x Centimeter] The wound bed is tissue, and the peri wound in					
	indicated, " Area less than 0.1 cm. T granular tissue, and	dated 5/23/18 at 3:47 p.m. measures 1.2 cm x 2.1 cm x the wound bed is shiny pink d the peri wound in healthy, e. Treatment includes includes					
	6/11/18 at 11:46 a.r stag-able [sic] ulcer resolving Area m less than 0.1 cm. T granular tissue, and	stant progress note dated m. indicated, " does have a r on her right buttock but it is neasures 1.2 cm x 2.1 cm x 'he wound bed is shiny pink d the peri wound in healthy, e. Treatment includes includes nift"					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00452	B. WING		l l	C 21/2018
	PROVIDER OR SUPPLIER	CENTER 109 COUR	DRESS, CITY, S RT AVENUE : DNE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 570	specified " Area rand is a dry, lifted, or considered a stage scabbed with a heal wound in healthy, pincludes includes care of the pressure ulcer. The facility policy of the facil	dated 6/13/18 at 4:12 p.m. measures 0.3 cm x 0.3 cm, dark brown scab. It still two pressure area that is ling wound bed. The peri ink and blanchable. Treatment alazinc q shift"  p.m. registered nurse (RN)-A lan lacked documentation of RN-A stated, "Is my date the care plan, and I  are Plans, Comprehensive evised December 2016, asment of residents are lans are revised as the residents and the residents'	2 570			
	ensure care plans a resident's current si	ee could educate the				
	The DON or design system to ensure or	the policies/procedures.  ee could develop a monitoring ngoing compliance.  R CORRECTION: Twenty-one				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			7. BOILDING.			
		00452	B. WING			1/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE : ONE, MN 550			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21025	Continued From page 13		21025			
21025	MN Rule 4658.0615 Food Temperatures		21025			7/13/18
	40 degrees Fahren or below, or 150 de centigrade) or abov food" means any for and temperature corapid and progressi toxigenic microorga.  This MN Requirements: Based on observation review, the facility for were dated when the second	ent is not met as evidenced ion, interview, and document ailed to ensure supplements nawed for 8 of 8 residents (R7,		Corrected		
	R5, R3, R32, R8, R6, R30, and R20) who received supplements.  Findings include:  On 6/18/18, at 1:58 p.m. seven chocolate and vanilla Lyons Mighty Shake supplement cartons were observed undated and thawed in the refrigerator of the main dining room. The cartons had instructions not to serve more than 14 days after being thawed. The dietary manager (DM) confirmed findings. The DM reported she was not aware of the instructions on the package. The					
	supplements, and we they had been thaw know how long the once thawed.  The Lyons Readyca undated, under she	reported she stocked the was not aware of how long wed. DA-A reported she did not supplements could be served are Nutritional Product Line elf life directed the product was nan 14 days unopened.				
	SUGGESTED MET	THOD FOR CORRECTION:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:	<del></del>	COMP	LETED
		00452	B. WING		06/2	2 1/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER 109 COUF	RT AVENUE	SOUTH		
OANDOI	ONE HEALTH OAKE	SANDSTO	NE, MN 550	072		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21025	Continued From pa	ge 14	21025			
	review and/or revise ensure food is labe per manufacture's of food-borne illness.  The DM or designe appropriate staff or The DM or designe system to ensure or the person of the person	er (DM) or designee could e policies and procedures to I with a date and left thawed directions to prevent ee could educate the in the policies/procedures. ee could develop a monitoring ingoing compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			7/13/18
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.					
	by: Based on observative review, the facility finfection control pracontamination during residents (R25) remonitoring. In additional the Legionella policinguidance for manage Legionella cases and review of the second resident resident review of the second revie	ent is not met as evidenced ion, interview, and document ailed to ensure proper actices to prevent cross ng a glucometer check for 1 of eviewed for blood glucose ion, the facility failed to ensure ey and procedure provided gement of suspected nd testing criteria. This had ict all 37 residents who resided		Corrected		

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU		1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
				A. BUILDING:	<del></del>		_
		00452		B. WING			C 21/2018
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER		RT AVENUE : ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	nge 15		21375			
	Findings include:						
	R25's Admission R indicated R25's dia mellitus type 2, and methicillin resistant (MRSA).	gnoses included I R25 was a carr	l diabetes ier of				
	R25's admission Minimum Data Set (MDS) dated 5/10/18, indicated R25 was cognitively intact, and had a surgical wound.						
	R25's care plan initiated 5/11/18, directed nursing to do glucometer checks as ordered.						
	R25's progress not to self check blood nursing staff.						
	R25's Physician Or checks four times of						
	On 6/18/18, at 3:53 entered R25's room precautions for MR her hands, and har own blood glucose glucometer. R25 cl finger with the lanc sample. R25 place that had been place removed the test si RN-B gloved, clear the insulin, injected glucometer up from removed her glove carried the glucomed the medical and put the glucome cart. RN-B then glo	n. R25 was on comes A in a wound. Inded R25 the sunded R25 the sunded R25 the sunded R25 the sample on the sample on the sample on the site for a R25's tray table in R25's tray table in the refer in her left hattion cart with he seter directly on the R25 on the seter directly on the R25 on the seter directly on the R25 on the R2	ontact RN-B sanitized pplies to do his acility or, poked his his blood to the test strip eter, and the result. the injection of picked the e. RN-B nands, and and. RN-B r right hand, the medication				

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00452	B. WING			C
		00452			06/2	21/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE ONE, MN 55			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	it in a purple Sani-ver RN-B stated the glug glucometer, and ver precautions. RN-B glucometer, and she directly on the med there was a risk for stated she should hefore setting it on then wiped off their Sani-wipe.  On 6/21/18, at 3:45 (DON) verified their contamination with placed on the medithe facility was goin R25 his own person. The facility policy A Monitoring System Cleaning undated, super Sani-cloth to glucometer, thorough the treated glucometer to remain wet for a The facility policy Wundated, lacked gu suspected Legione criteria and parameter on 6/21/18, at 4:04 (DON) verified the management of suspenses and state of the suspenses of	d the glucometer and wrapped vipe, and placed it in a cup. ucometer was a shared wrified R25 was on contact verified R25 handled the le set the unclean glucometer ication cart. RN-B verified cross contamination, and have cleansed the glucometer the medication cart. RN-B medication cart with a purple of p.m. the director of nursing e could be a risk of cross the unclean glucometer cation cart. The DON stated and glucometer.  Ssure Prism Blood Glucose Recommended Use and directed nursing to use a clean clean and disinfect the ghly wet the glucometer, lay geter on paper towel and allow full 2 minutes and let air dry.  Water Management System idance for management of lla cases, and lacked testing policy did not address the spected Legionella cases. The ould look further at the testing				
	SUGGESTED MET	HOD FOR CORRECTION:				

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STATE FORM 6899 XO2U11 If continuation sheet 17 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	<del></del>	C	
		00452	B. WING			21/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE S			
(X4) ID PREFIX TAG	D SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDE IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ige 17	21375			
21426	review and/or revise ensure glucometers properly to prevent blood-borne pathog could revise policie  The DON or design appropriate staff or The DON or design system to ensure of TIME PERIOD FOR (21) days.	nee could educate the in the policies/procedures. nee could develop a monitoring ingoing compliance. R CORRECTION: Twenty-one A.04 Subd. 3 Tuberculosis	21426			7/13/18
	maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	e provider must establish and nensive tuberculosis ogram according to the most is infection control guidelines of States Centers for Disease action (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis on that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.				

Minnesota Department of Health						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE			
	-	SANDSTO	ONE, MN 55	072		
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
17.0		,	.,	DEFICIENCY)		
21426	Continued From no	go 10	21426			
21426	Continued From pa	ge 18	21426			
	TI: 141 D :					
		ent is not met as evidenced				
	by:	and document review, the		Corrected		
		ure tuberculosis (TB) baseline		Corrected		
		is and two-step tuberculin skin				
	tests (TSTs) were done for 4 of 5 employees					
	(NA-B, RN-B, DA-A, NA-C) prior to first resident					
	contact upon hire.	, , ,				
	Findings include:					
		NA)-B was hired on 5/15/18,				
		nt contact date was 5/17/18.  eline symptom screening that				
		ed. NA-B had a two-step TST				
		e, zero millimeter (mm)				
	results.	o, 2010 1111111110101 (111111)				
	Registered nurse (F	RN)-B was hired on 3/12/18,				
	and the first resider	nt contact date was 3/13/18.				
		ed baseline symptom				
		irst TST was given on				
		on 3/29/18, with negative, zero				
		nad a second TST given on				
		ead on 4/15/18, with negative,				
		N-B lacked evidence of a				
	negative baseline s	ymptom screening and				
	nogative 101 pilot	to not contact.				
	Dietary Aide (DA)-A	was hired on 3/17/18, and fist				
		21/18. DA-A's baseline				
		was completed on 3/27/18.				
		as given on 3/27/18 and read				
	on 3/30/18 with neg	jative, zero mm results.				
	DA-A's second TST	was given on 4/16/18, and				
	read on 4/18/18, wi	th negative, zero mm results.				

			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			C	
	00452		B. WING			21/2018	
PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ONE HEALTH CARE	CENTER						
(EACH DEFICIENC)	Y MUST BE PREC	EDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO	N SHOULD BE	(X5) COMPLETE DATE	
DA-A lacked a base negative TST prior  NA-C was hired on contact date was 5, baseline symptom facility lacked evided TST prior to first re  On 6/21/18, at 4:09 (DON) verified the and two-step TSTs prior to first resident been.  The facility policy ETuberculosis dated employees to be so two-step tuberculin symptom screening employment. The pscreening to be don but prior to the employment of the employment	eline symptom to first contact 5/17/18, and /31/18. NA-C screening on ence of a negation of the contact of p.m. the dire baseline symptom were not completed for TE skin test or begin only and proof of the contact of the prior to begin only and proof of the contact of the prior to begin only and proof of the policies and yees completed, and have an test (TST) prime the could devent the policies/prime could devent the prime could be prime coul	first resident completed a 6/5/18, and the ative two-step t.  ctor of nursing otom screening, apleted for staff d should have being a lood test and aning cedure directed of employment, assignment.  ORRECTION:  designee could procedures to a baseline negative first rior to resident cate the procedures.	21426	BEI IGIENOT)			
TIME PERIOD FOR	R CORRECTI	ON: Twenty-one					
	PROVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR L  Continued From pa  DA-A lacked a base negative TST prior  NA-C was hired on contact date was 5 baseline symptom facility lacked evide TST prior to first re  On 6/21/18, at 4:09 (DON) verified the and two-step TSTs prior to first resider been.  The facility policy E Tuberculosis dated employees to be so two-step tuberculin symptom screening employment. The p screening to be do but prior to the emp  SUGGESTED MET  The director of nurs review and/or revis ensure new employ symptom screening step tuberculin skir contact.  The DON or design appropriate staff or  The DON or design system to ensure of	OF CORRECTION  O0452  PROVIDER OR SUPPLIER  ONE HEALTH CARE CENTER  SUMMARY STATEMENT OF DEF (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING  Continued From page 19  DA-A lacked a baseline symptom negative TST prior to first contact  NA-C was hired on 5/17/18, and contact date was 5/31/18. NA-C baseline symptom screening on facility lacked evidence of a nega TST prior to first resident contact  On 6/21/18, at 4:09 p.m. the dire (DON) verified the baseline symp and two-step TSTs were not com prior to first resident contact, and been.  The facility policy Employee Scre Tuberculosis dated 5/17/17, dire employees to be screened for TE two-step tuberculin skin test or b symptom screening prior to begin employment. The policy and prod screening to be done after offer of but prior to the employee's duty a  SUGGESTED METHOD FOR C  The director of nursing (DON) or review and/or revise policies and ensure new employees complete symptom screening, and have a step tuberculin skin test (TST) pr contact.  The DON or designee could edu appropriate staff on the policies/g  The DON or designee could dev system to ensure ongoing complete system to en	PROVIDER OR SUPPLIER  STREET AD  109 COUR SANDSTO  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  DA-A lacked a baseline symptom screening and negative TST prior to first contact.  NA-C was hired on 5/17/18, and first resident contact date was 5/31/18. NA-C completed a baseline symptom screening on 6/5/18, and the facility lacked evidence of a negative two-step TST prior to first resident contact.  On 6/21/18, at 4:09 p.m. the director of nursing (DON) verified the baseline symptom screening, and two-step TSTs were not completed for staff prior to first resident contact, and should have been.  The facility policy Employee Screening for Tuberculosis dated 5/17/17, directed all employees to be screened for TB using a two-step tuberculin skin test or blood test and symptom screening prior to beginning employment. The policy and procedure directed screening to be done after offer of employment, but prior to the employee's duty assignment.  SUGGESTED METHOD FOR CORRECTION:  The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure new employees complete a baseline symptom screening, and have a negative first step tuberculin skin test (TST) prior to resident	ONE HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DA-A lacked a baseline symptom screening and negative TST prior to first contact.  NA-C was hired on 5/17/18, and first resident contact date was 5/31/18. NA-C completed a baseline symptom screening, and the facility lacked evidence of a negative two-step TST prior to first resident contact.  On 6/21/18, at 4:09 p.m. the director of nursing (DON) verified the baseline symptom screening, and two-step TSTs were not completed for staff prior to first resident contact, and should have been.  The facility policy Employee Screening for Tuberculosis dated 5/17/17, directed all employees to be screened for TB using a two-step tuberculin skin test or blood test and symptom screening prior to beginning employment. The policy and procedure directed screening to be done after offer of employment, but prior to the employee's duty assignment.  SUGGESTED METHOD FOR CORRECTION:  The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure new employees complete a baseline symptom screening, and have a negative first step tuberculin skin test (TST) prior to resident contact.  The DON or designee could educate the appropriate staff on the policies/procedures.  The DON or designee could develop a monitoring system to ensure ongoing compliance.	OPENDED OF CORRECTION    Dentification Number:   A BUILDING:   B. WING	OPCORRECTION  OD452  B. WING  OD467  B. WING  OD67  PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  109 COURT AVENUE SOUTH  SANDSTONE, MN 55072  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)  DA-A lacked a baseline symptom screening and negative TST prior to first contact.  NA-C was hired on 5/17/18, and first resident contact date was 5/31/18. NA-C completed a baseline symptom screening on 6/5/18, and the facility lacked evidence of a negative two-step  TST prior to first resident contact.  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21426	Continued From pa	ge 20	21426			
	(21) days.					
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights		21800			7/13/18
	residents shall, at a are legal rights for stay at the facility of treatment and main that these are described written statement of responsibilities sets case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and orgal advocacy and legal residential program accommodations significant to the alministrator by the written statement to patients, resident to the administrator person, consistent of Practices Act, and significant in the written statement of the administrator person, consistent of the administrator person administrato	tion about rights. Patients and admission, be told that there their protection during their in throughout their course of attenance in the community and ribed in an accompanying if the applicable rights and forth in this section. In the mitted to residential programs in 253C.01, the written of describe the right of a did or older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in s. Reasonable hall be made for those with pairments and those who other than English. Current procedure the rection findings of state and ties, and further explanation of ant of rights shall be available the training the request or other designated staff with chapter 13, the Data section 626.557, relating to				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		С	
		00452	B. WING		1	1/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE ONE, MN 55			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21800	Continued From page 21		21800			
	facility failed to ens Advanced Beneficia residents (R15, R3 ended, and they re	and document review, the ure the Skilled Nursing Facility ary Notice was given to 2 of 2 3) whose Medicare A services mained living in the facility.		Corrected		
	Findings include:					
	[SNF] Beneficiary F completed by the fat Medicare Part A se last covered day of The form indicated the discharge from when benefit days remained in the fact record review reveat CMS-10123 Notice (NOMNC) however Advance Beneficial	Protection Notification Review), acility, revealed R15's rvices started 2/12/18, and the Part A service was 5/2/18. the "Facility/provider initiated Medicare Part A services were not exhausted." R15 cility after 5/2/18. Further aled the facility had provided of Medicare Non-Coverage r, a Skilled Nursing Facility ry Notice of Non Coverage EMS-10055) was not provided.				
	revealed R33's Med 12/27/17, and the last service was 1/29/18 "Facility/provider in Medicare Part A se not exhausted." R3 1/29/18. Further refacility had no docu CMS-10123 NOMN Form CMS-10055)  On 6/19/18, at 11:3 worker (SW)-A stat notices needed to be remembered giving	dicare Part A services started ast covered day of Part A services started ast covered day of Part A services when indicated the itiated the discharge from rvices when benefit days were a remained in the facility after ecord review revealed the imentation that it provided IC. In addition, SNF ABN was not provided.  6 a.m. the facility social sed she did not know that two be given. The SW stated she is the CMS-10123 NOMNC to find documentation showing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00452	B. WING		<b>I</b>	C <b>21/2018</b>
	PROVIDER OR SUPPLIER	109 COU	DDRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	SANDST	ONE, MN 550	072		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21800	Continued From pa	ge 22	21800			
	not given the SNF-/	The SW confirmed she had ABN CMS-10055 to either R15 not know of this requirement.				
	provided a brief ove but does not identif	at Handbook dated 1/1/15, erview of Medicare coverage, y the correct CMS ding Medicare Beneficiary				
		n of Medicare Beneficiary ted but not received from the				
	Based on interview and document review, the facility failed to ensure a resident's grievance regarding missing personal property was followed up on and addressed for 1 of 2 residents (R34) reviewed for grievances.					
	Findings include:					
		ecord printed 6/21/18, gnoses included a mild nt.				
	6/10/18, indicated F	imum Data Set (MDS) dated R34 was cognitively intact, and was understood by others.				
		ange MDS dated 10/5/17, y important to R34 to keep her				
	as a vulnerable adu and exploitation. R	iated 12/28/17, identified R34 llt, and was at risk for abuse 34's care plan indicated R34 with dressing at times.				
	On 6/18/18, at 6:39	p.m. R34 stated she had				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				A. BUILDING:			_
		00452		B. WING			C 21/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER		RT AVENUE S ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21800	Continued From page 23			21800			
	been missing a bra since last winter. R34 stated the facility had told her they were looking for it, and had told her they would replace it, but didn't.						
	stated she was awa	2 p.m. social worker are of R34's missing for it, but were unab	bra, and				
	usually fills out a comissing item form, she was unable to regarding her miss would interview R3 stated they had che SW-A stated they u result. SW-A verifie form pertaining to F stated they might re SW-A stated she will determine if she had R34 had not stayed	i3 a.m. SW-A stated oncern grievance for and follow up that we find one for R34's coing bra. SW-A stated 4 that day and followecked other resident usually tell the reside ed she did not find a R34's missing bra. Seplace it if it had bee would check with R34 and any other bras. State out overnight outside would have been lost	m, or ay, but oncern I she /-up. SW-A rooms. nt the grievance W-A n stolen. I to V-A stated de of the				
	sitting in the day ro station doing puzzle R34 did not have a few staff stopped b was taken to her ro assistant (NA)-A. I any bras and said t was the only bra sh not have any bras a one had talked to h bra.	55 a.m. R34 was obsom across from the es, and watching telebra on under her shy to interact with her oom per her request R34 stated she did nihe bra she bought and had. NA-A verified at that time. R34 stater this week about h	nurse's evision. irt, and a . R34 by nursing ot have nd lost I R34 did ited no her missing				
	On 6/21/18, at 11:0	8 a.m. R34 stated s	he felt				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00452		B. WING		C <b>06/21/2018</b>		
NAME OF F	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	1 00,2	
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE			
0(0) ID	CLIMMA DV CTA		NE, MN 550		DNI .	(2/5)
(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 SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 24	21800			
	uncomfortable without a bra and was embarrassed sometimes, especially when the male staff assisted her. R34 stated she was very upset that someone took her bra. R34 stated she bought the bra when it was cold outside, before Christmas.					
	The facility policy Grievances dated 5/17, directed the facility to provide a written notice of resolution of the complaint and provide it upon request as soon as possible to the complainant after the complaint is received, and within 30 days.					
	SUGGESTED MET	HOD FOR CORRECTION:				
	The social worker (SW), director of nursing (DON) or designee could review and/or revise policies and procedures to ensure appropriate notices are provided to residents and/or the resident representative at the end of skilled Medicare services.					
	(DON) or designee policies and proced grievances, both vo	SW), director of nursing could review and/or revise lures to ensure resident piced and in writing, are lely and satisfactory manner.				
		esignee could educate the the policies/procedures.				
		esignee could develop a to ensure ongoing compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			7/13/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00.450		B. WING		0000	
		00452		B. WINO		06/2	1/2018
NAME OF	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER		RT AVENUE : ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN 'MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21805	Continued From page 25			21805			
	Subd. 5. Courteouresidents have the courtesy and respensively employees of or pehealth care facility.	right to be treated ct for their individu	with uality by				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the State Agency for 3 of 4 residents (R33, R28, R12) reviewed for abuse.  Findings include:  R33's Admission Record printed 6/21/18, indicated R33's diagnoses included history of cerebral infarction (stroke) without residual effects.			Corrected			
	R33's quarterly Min 6/8/18, indicated R3 required limited to r activities of daily livi	33 was cognitiveÌy noderate assistan	intact, and				
	R33's care plan dat a vulnerable adult, a abuse or the potent reported per the fac staff were aware of	and any situation i ial for abuse woul cility protocol, and	identified as d be indicated				
	On 6/18/18, at 6:00 and stated a female too tight and it hurt. identified staff mem reported it to other a purposeful act.	e staff had pulled o R33 stated he ha ber that it hurt, ar	up his pants ad told the nd had				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00452	B. WING			C <b>21/2018</b>
SANDSTONE HEALTH CARE CENTER 109 COUR			DDRESS, CITY, S RT AVENUE S ONE, MN 550	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21805	Continued From page 26 On 6/18/18, at 8:25 p.m. the incident regarding R33 was reported to the director of nursing (DON).  An facility report indicated the incident was		21805			
	3:34 p.m.  On 6/19/18, at 4:11 (DON) was intervier notified the administ of abuse immediate to keep R33 safe, a concerns that morn facility goes by the reported to the SA. was no serious injuit. The identified sta	p.m. the director of nursing wed and stated she had strator about R33's allegations ely, implemented interventions and talked to R33 about his ning. The DON stated the resident's perception, so it was The DON stated since there ry, they had 24 hours to report off member was re-educated, g with the resident at that	5			
	reporting guidelines needed to be report R28's Admission Ro	ecord printed 6/21/18, gnoses included Alzheimer's				
	was a vulnerable ad	iated 12/28/17, indicated R28 dult, and any situation or potential abuse would be protocol.				
	indicated another re while she sat in a d hallway. The other shoulder and pulled	es dated 5/14/18, at 8:00 a.m. esident was standing over R28 ining room chair in the resident pushed R28 on the don her elbow, and yelled at of the chair." R28 was				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:		С		
		00452	B. WING		- 06/21/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE			
240.15	CLIMMADY CTA		NE, MN 550			0.(5)
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ige 27	21805			
	confused, and asked why the other resident was pushing her. Staff intervened and no injuries were noted.					
	R28's allegation of abuse was submitted to the SA on 5/14/18 at 5:13 p.m. more than 9 hours after the alleged abuse.					
		ecord printed 6/21/18, gnoses included dementia.				
	had a cognitive imp directed staff to pro	ciated 4/6/18, indicated R12 pairment. R12's care plan povide assistance with personal and incontinent cares.				
	R12 was found with chest with a sheet t and dried feces on sheets. A report for	6/30/18, at 10:30 p.m. indicated in his arms crossed over his tucked around his upper body, his hands, gown, legs, and it this incident was submitted to it 10:16 a.m. more than 5 days buse occurred.				
		p.m. the DON verified the e were reported late to the SA.				
	Vulnerable Adult Red defined abuse as a unreasonable confi punishment with remental anguish. The	buse Prevention and eporting Plan dated 5/17, willful infliction of injury, mement, intimidation, or sulting physical harm, pain, or he facility policy directed staff I abuse within 2 hours to the SA.				
	SUGGESTED MET	THOD FOR CORRECTION:				
		sing (DON) or designee could e policies and procedures to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
						C
		00452	B. WING		06/2	21/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE : ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 28	21805			
	ensure allegations of State Agency timely	of abuse are reported to the /.				
	The DON or design appropriate staff on	nee could educate the the the policies/procedures.				
	The DON or designee could develop a monitoring system to ensure ongoing compliance.					
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					

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