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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XO2U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00452

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245454**

2.STATE VENDOR OR MEDICAID NO.
(L2) **475213900**

3. NAME AND ADDRESS OF FACILITY
(L3) **SANDSTONE HEALTH CARE CENTER**
(L4) **109 COURT AVENUE SOUTH**
(L5) **SANDSTONE, MN** (L6) **55072**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/17/2017**

6. DATE OF SURVEY **08/13/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 08/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/15/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/31/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

DEPARTMENT OF HEALTH

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: XO2U

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(L3) **SANDSTONE HEALTH CARE CENTER**
(L4) **109 COURT AVENUE SOUTH**
(L5) **SANDSTONE, MN** (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
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/17/2017**
6. DATE OF SURVEY **06/21/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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13.Total Certified Beds **45** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date:
Kimberly Settergren, HFE NE II 07/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/30/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 6/18/18, through 6/21/18, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address patient/client population including, but not limited to persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plan in their emergency preparedness plan. This had the potential to affect all 37 resident residing in the facility. Findings include:	E 007	The Emergency plan will be updated to address the entire resident population, and address persons at risk and type of services the facility can provide in an emergency. The plan will also include delegations of authority and succession plans.	7/20/18

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

Electronically Signed | 07/13/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 007	Continued From page 1 Review of the facility Emergency Plan lacked components about the resident population: the persons at-risk, the type of services the facility has the ability to provide in an emergency, and the continuity of operations, including delegations of authority and succession plans. On 6/19/18, at 9:00 a.m. the administrator and project manager stated the facility had conducted a risk assessment as part of their emergency plan, but had not yet completed all of the required components for the emergency preparedness (EP) requirements. The administrator confirmed the facility did not have an emergency plan that included the specifics about their resident population: the persons at-risk, the type of services the facility has the ability to provide in an emergency, and the continuity of operations, including delegations of authority and succession plans.	E 007		
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.	E 009		7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 009	Continued From page 2 * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure documentation of collaboration efforts with local and state emergency preparedness authorities. This had the potential to affect all 37 residents who resided in the facility. Findings include: The facility emergency preparedness plan dated 5/17/17, identified local, county and federal emergency contacts, but lacked documentation of coordination and collaboration efforts with the pertinent authorities. On 6/19/18, at 9:00 a.m. the project manager (PM) stated she had telephoned local and county emergency contacts, but did not have any memorandums of understanding or other documentation to indicate coordination or collaboration efforts with the pertinent authorities.	E 009	The facility will collaborate efforts with local and state emergency preparedness authorities to develop and maintain an emergency preparedness plan. This plan will also be reviewed annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 3	E 026		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their policies and procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 37 residents residing in the facility.	E 026	The facility will develop a policy and procedure which address the role of the facility under a declared waiver by the secretary of state. It will be in accordance with section 1135 of the act.	7/20/18

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E 026	Continued From page 4 Findings include: The facility emergency preparedness plan and binder failed to include a policy or to address the role of the facility under a waiver by the Secretary in a difference facility or evacuation site. On 6/19/18, at 9:00 a.m. the administrator and project manager (PM) stated this would be done if an emergency was declared, but they did not have a policy written on it.	E 026		
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).	E 033		7/20/18

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E 033	Continued From page 5 *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a communication plan which included a method for sharing information and medical documentation for residents under the facility care with other health providers to maintain the continuity of care. This had the potential to affect all 37 residents residing in the facility. Findings include: On 6/19/18, at 9:00 a.m. the facility emergency policies and procedures were reviewed with the administrator and project manager (PM). During the review, it was revealed and verified the facility did not develop a communication plan, which included a method for sharing information and medical documentation for residents under the facility care with other health providers to maintain the continuity of care.	E 033	The facility will develop a communication plan which includes the method of sharing information and medical documentation for residents under the care of the provider and will provide continuity of care in the event of an emergency.	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7)	E 034		7/20/18

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E 034	Continued From page 6 [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness communication plan included a means of providing information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center or Designee. This had the potential to affect all 37 residents residing in the facility. Findings include:	E 034	Facility will develop an emergency preparedness communication plan which will provide information about the facilities occupancy needs and its ability to provide assistance to the authority having jurisdiction.	

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E 034	Continued From page 7 On 6/19/18, at 9:00 a.m. the Emergency Preparedness Plan dated 5/17/17, was reviewed and failed to include a policy/procedure related to the communication of the facility's occupancy, needs, and the general condition and location of residents. The administrator confirmed the facility had not developed a policy.	E 034		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an emergency preparedness communication plan which included a method for sharing appropriate information from the plan to the residents and family members. This had the potential to affect all 37 residents currently residing the facility, as well as their families and/or representatives. Findings include: On 6/19/18, at 9:00 a.m. the facility Emergency Preparedness Plan was reviewed with the administrator and the project manager (PM), who confirmed the plan did not address the method	E 035	The facility will develop an emergency preparedness communication plan for sharing appropriate information to residents and family members.	7/20/18

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E 035	Continued From page 8 for sharing information for the plan with residents and families. The PM stated they had not considered sharing the plan with residents or families and had not yet considered what would be appropriate to share.	E 035		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set	E 039		7/20/18

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E 039	Continued From page 9 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure efforts to participate in a full-scale community or tabletop exercise had been coordinated. This had the potential to affect all 37 residents residing in the facility. Findings include: The facility Emergency Preparedness Plan (EPP) dated 5/17/17, was reviewed on 6/19/18, at 9"00 a.m. and lacked documentation of efforts to coordinate participation in a full-scale community	E 039	The facility will coordinate and participate in a tabletop exercise to test the emergency plan and coordinate a date to do a full scale exercise at a minimum of annually. This meeting is scheduled for Tuesday, August 7th @ 1pm. We have representatives coming from the following places: Essentia Sandstone, hospital, Golden Horizons AL, Sandstone City Administrator, Pine county emergency preparedness - 2 reps, Sandstone fire chief, Don Sheldrew from East Central	

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E 039	Continued From page 10 exercise or tabletop exercise. The EPP failed to provide direction to participate in a full-scale community exercise or tabletop exercise. On 6/19/18, at 9:00 a.m. the administrator and project manager (PM) confirmed they had not yet planned or participated in a full-scale or table top community exercise. The PM stated they had internally responded to a tornado warning on 6/16/16, but had not done any community based planning, coordination or exercises.	E 039	Emergency Preparedness Coalition, Sandstone Ambulance representative's, and Rose from the Sandstone golf course - where our evacuation site is. The following 3 people will represent Sandstone Health Care Center: Tom Opatz Administrator, Erica Stapek, RN DON and Jennifer Colby EP steward	
F 000	INITIAL COMMENTS A recertification survey was conducted 6/18/18, through 6/21/18, 2018 and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5454010 was completed and was found to be substantiated at F580 and F726. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		7/13/18

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F 580	Continued From page 11 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 12 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the physician was notified upon a change in condition for 2 of 4 residents (R18, R25) reviewed for notification of change. Findings include: R18's Admission Record printed 6/21/18, included diagnoses of type two diabetes, dementia and anxiety. R18's quarterly Minimum Data Set (MDS) dated 5/3/18, indicated R18 had severely impaired cognition. The MDS further indicated R18 required extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and eating. The MDS indicated R18 did not walk, did not have a swallowing disorder, and received insulin injections on seven of seven days during the assessment period. R18's Order Review Report signed by the physician on 5/11/18, included orders to check R18's blood sugar four times a day for diabetes. The Facility's Standing orders signed 6/7/18, directed to notify the physician if two blood sugar results are less than 70 in a 24 hour period and/or	F 580	Element #1: Resident R18 & R25's blood sugars were reviewed and any concerns were brought to MD/NP's attention Element #2: All other residents that had the potential to be affected by this deficient practice has had their blood sugars assessed. Element#3: To prevent this from happening again, nurses were instructed thru shift report starting 6/21/2018 to review the following policies: 1)Change n resident's condition or status 2)Medication & treatment orders 3)Acute condition changes - clinical protocol. In "Friday Notes" (which is a weekly update regarding facility information that all staff are required to read)on 6/22/2018 it was stated to nurses to review the above policies also. On 7/2/2018 a nurses meeting was held and nurses again were educated on the above policies and the facility standing orders with special attention brought to the diabetes part of the standing orders. Element #4: To maintain compliance with F580 the nurse manger, DON or designee will review all residents with blood glucose monitoring weekly x 4weeks, then	

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F 580	Continued From page 13 a change in condition. The Standing Orders further directed for blood sugars of 60 or below give 240 milliliters (ml) of 2% milk, skim milk, or orange juice with graham crackers, cheese or a half of a sandwich. Repeat blood sugar check 30 minutes later. For blood sugars of 50 and below if unable to swallow; give one tube of glucose gel and recheck the blood sugar in 15 minutes. If no change in blood sugar give another tube of glucose gel. Give up to 3 tubes waiting 15 minutes in between. If the resident was unable to swallow give Glucagon (glucose) 1 milligram (mg) intramuscularly (IM) and recheck the blood sugar in 15 minutes. If no increase in the blood sugar or the blood sugar continues to drop, contact the physician immediately. R18's care plan revised on 4/14/18, indicated clinical monitoring for diabetes. Interventions directed to observe and report as needed any signs or symptoms of hypoglycemia (low blood sugar). Signs and symptoms included sweating, tremors, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, and staggered gait. R18's Medication Administration Record (MAR) dated 5/18, indicated on 5/13/18, at 8:00 a.m. R18's blood sugar was 50, and at 12:00 p.m. R18's blood sugar was 59. R18's progress note dated 5/13/18, at 2:45 p.m. indicated R18 had been lethargic all day, and was combative with cares. Many attempts were made to offer R18 fluids but R18 refused. R18 had not eaten, and pushed away staff's hands. R18's blood sugar was low in parameter. R18's family was present and requested R18 be sent to the hospital. R18 was then sent to the hospital. The	F 580	2x/month x 3 months and then as need basis upon findings. Negative findings will be reported at the quarterly Quality meetings. Element #5: The facility will be in full compliance with F580 by 7/13/2018	

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F 580	Continued From page 14	F 580		

progress note lacked evidence of assessment, treatments or notification of the physician when R18's blood sugar levels were low.

On 6/19/18, at 10:49 a.m. R18's family representative (F)-A was interviewed, and stated on Mother's Day, R18's family came to the facility about noon. R18 had been incontinent of stool, and the family had to ask for R18 to be changed. R18 had not been dressed or washed, and smelled bad. F-A further stated R18's blood sugar was low, and R18 had to go to the hospital. F-A stated R18's blood sugar was 39 in the ambulance. F-A stated the facility did not catch the low blood sugar, the family did.

On 6/21/18, at 10:43 a.m. licensed practical nurse (LPN)-A stated if a resident had a condition change, LPN-A would assess the resident and let the registered nurse (RN) know. If it was during the weekend, LPN-A would notify the on-call supervisor. LPN-A would give the resident food or something to drink if they were coherent and then would monitor. LPN-A stated If the resident was not coherent, she would give glucose gel or IM glucose. LPN-A further stated the facility had standing orders to use, and they were to notify the on call physician.

On 6/21/18, at 11:14 a.m. LPN-B stated if a resident had a change in condition, she would assess the resident, and let the RN know. If it was during the weekend, LPN-B would notify the on-call supervisor. LPN-B further stated if a resident had a low blood sugar, the facility had standing orders and she would follow the facility's protocol. LPN-B stated there was a list of on call physicians, and would call if needed.

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On 6/21/18, at 1:57 p.m. the director of nursing (DON) stated condition changes were often reported by the nursing assistant (NA), during report and by using the Stop and Watch forms. The nursing staff could call the DON or the RN managers to see what they need to do. In the afternoon, or on the weekend when there was not a supervisor present, the DON would encourage the nurses to call her, or the RN care manager. The DON stated nursing staff could also notify the physician or call 911, depending what was going on. The DON stated typically the facility does not have to send residents to the hospital due to a low blood sugar because it is taken care of at the facility. The DON stated staff were evaluated to assess their competencies, skill, and knowledge during orientation, with on-going training, and if there were any issues she would do some one-to-one training. The DON stated the nurse who was working with R18 the day her blood sugars were low and she was transported to the hospital, was new to the facility, and it was a busy morning medication pass. The nurse said she did give R18 some milk, but did not document it. R18 had been combative earlier and it was overwhelming for her. The DON stated the nurse was re-educated on standing orders, asking for help from the other nurse, calling the DON and calling the physician. The also nurse worked one on one with another nurse. Since R18 was alert, the DON would expect staff to give milk, recheck the blood sugar, check the standing orders and assess the resident's condition. R18 could have received Glucagon per standing orders. The DON further stated if those things would have been done, the outcome most likely would have been different.

The facility's Nursing Care of the Resident with

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Diabetes Mellitus policy dated 12/15, directed the severity of hypoglycemia was determined by a combination of blood sugar results and clinical symptoms. For residents who are symptomatic such as lethargy and drowsy and able to swallow, immediately give an oral form of rapidly absorbed glucose (four ounces of juice or five to six ounces of soda.) Recheck the blood sugar in 15 minutes. If indicated repeat the juice and recheck the blood sugar in 15 minutes. If no improvement notify the physician.

The facility's Change in a Resident's Condition or Status policy dated 12/16, directed the facility would promptly notify the resident, the attending physician and a representative of changes in the resident's medical or mental condition and or status.

R25's Admission Record printed 6/21/18, indicated R25's diagnoses included diabetes mellitus (DM) type 2 with other diabetic neurological complication, chronic kidney disease, and atherosclerotic heart disease.

R25's admission MDS dated 5/10/18, indicated R25 was cognitively intact.

R25's care plan dated 5/11/18, indicated R25 was to have blood sugar checks as ordered, and directed staff to observe and report any signs and symptoms of hyperglycemia (elevated blood sugars) or hypoglycemia.

R25's signed Physician Orders dated 6/11/18,

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included orders for Novolog mix 70/30 suspension (fast-acting and intermediate-acting insulin for diabetes) 100 units subcutaneously (tissue under the skin) one time daily, 80 units subcutaneously one time daily, and 100 units subcutaneously in the morning.

R25's Admission History and Physical dated 6/4/18, indicated R25's blood glucose readings had been in the 200s but were decreasing. The physician documented R25 had hyperglycemia, and insulin was being adjusted.

R25's Physician Orders dated 6/4/18, indicated R25 had an order to self check blood glucose four times daily with nursing staff. The orders directed to update the nurse practitioner (NP) if blood sugar was less than 75 or greater than 300.

R25's Standing Orders dated 6/7/18, directed staff to notify the NP or physician if two blood glucose result were less than 70 or greater than 400 in a 24-hour period and/or condition change. If no condition change, notify the next business 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 11:44 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 4:29 p.m. 419
6/16/18, at 9:26 p.m. 522
6/16/18, at 10:41 p.m. 391
6/17/18, at 4:02 p.m. 486
6/17/18, at 8:53 p.m. 362
6/17/18, at 8:58 p.m. 362

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F 580	Continued From page 18 6/18/18, at 12:10 p.m. 451 6/18/18, at 4:02 p.m. 356 6/19/18, at 7:44 p.m. 361 R25 had several readings over 300, and had occurrences of at least 2 readings over 400 within 24 hours. R25's progress notes dated 6/15/18, indicated R25 had an order for self check blood glucose four times daily with nursing staff, and update the NP if blood sugar is less than 75 or greater than 300. R25's progress notes dated 6/16/18, at 9:26 p.m. indicated R25's blood sugar was 522, resident had eaten 3 puddings and an ice cream bar, and the nurse would follow up on the blood sugar. R25's progress notes dated 6/16/18, at 10:40 p.m. indicated R25's blood sugar was 391 at that time. R25's progress notes lacked documentation of notification of the physician or nurse practitioner of R25's elevated blood sugars and documentation of an assessment of R25's medical status or symptoms of hyperglycemia. On 6/21/18, at 12:12 p.m. the DON stated she would expect nursing to document elevated blood sugars, and notify the physician according to the physician orders and parameters. The DON stated the nurse should do an assessment, and document if the resident was experiencing any symptoms with blood sugars outside the parameter. The DON verified there was no documentation or indication if the physician or NP was notified of R25's elevated blood sugars.	F 580		

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F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		7/20/18

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F 582	Continued From page 20 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice was given to 2 of 2 residents (R15, R33) whose Medicare A services ended, and they remained living in the facility. Findings include: R15's form CMS-20052 (Skilled Nursing Facility [SNF] Beneficiary Protection Notification Review), completed by the facility, revealed R15's Medicare Part A services started 2/12/18, and the last covered day of Part A service was 5/2/18. The form indicated the "Facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted." R15 remained in the facility after 5/2/18. Further record review revealed the facility had provided CMS-10123 Notice of Medicare Non-Coverage (NOMNC) however, a Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNF ABN, Form CMS-10055) was not provided. R33's form CMS-20052 completed by the facility,	F 582	To prevent this from happening again, social worker was educated to use the following forms (CMS 10123-NOMNC & SNFABN) as appropriate. Social worker has reviewed back to April 1st 2018 to check on all residents that had the potential to be affected by this deficient practice. To Maintain compliance with F582 the social worker or designee will complete the required forms as per state/federal requirements. After obtaining the signed notices the social worker or designee will make a copy of signed notices and keep 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 reported at the quarterly Quality meetings Facility will be in full compliance with F582 as of 7/13/2018	

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F 582	Continued From page 21 revealed R33's Medicare Part A services started 12/27/17, and the last covered day of Part A service was 1/29/18. The form indicated the "Facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted." R33 remained in the facility after 1/29/18. Further record review revealed the facility had no documentation that it provided CMS-10123 NOMNC. In addition, SNF ABN Form CMS-10055) was not provided. On 6/19/18, at 11:36 a.m. the facility social worker (SW)-A stated she did not know that two notices needed to be given. The SW stated she remembered giving the CMS-10123 NOMNC to R33, but could not find documentation showing this had occurred. The SW confirmed she had not given the SNF-ABN CMS-10055 to either R15 or R33, as she did not know of this requirement. The facility Resident Handbook dated 1/1/15, provided a brief overview of Medicare coverage, but does not identify the correct CMS requirements regarding Medicare Beneficiary notices. A policy on provision of Medicare Beneficiary notices was requested but not received from the facility.	F 582		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		7/13/18

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respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman

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program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 585	Continued From page 24 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: 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: R34's Admission Record printed 6/21/18, indicated R34's diagnoses included a mild cognitive impairment. R34's quarterly Minimum Data Set (MDS) dated 6/10/18, indicated R34 was cognitively intact, understood others and was understood by others. R34's significant change MDS dated 10/5/17, indicated it was very important to R34 to keep her things safe. R34's care plan initiated 12/28/17, identified R34 as a vulnerable adult, and was at risk for abuse and exploitation. R34's care plan indicated R34 required assistance with dressing at times. On 6/18/18, at 6:39 p.m. R34 stated she had 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.	F 585	Element #1: R34's grievance was followed up by social worker and multiple bras were purchased so that resident could try them on and find a correct fitting one. Element #2: Currently there are no other residents with grievance's out. Element #3: To prevent this from happening again social worker was educated on timely follow-up for grievances. All staff were reminded on using the grievance forms in "Friday Notes" on 6/22/2018 including use of form for missing items and assisting residents or family members on filling them out. At Nurses meeting on 7/2/2018 a reminder about using the grievance forms was once again given. Element #4: To maintain compliance with F585 all grievances are now brought to daily IDT report to discuss and to seek a timely resolution on. DON or designee will audit the grievance book weekly X 4 weeks, then monthly X 3 months and then as need basis upon findings. Negative findings will be reported at the quarterly Quality meetings. Element #5: Facility will be in full compliance with F585 as of 7/13/2018	

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On 6/19/18, at 3:42 p.m. social worker (SW)-A stated she was aware of R34's missing bra, and stated they looked for it, but were unable to locate it.

On 6/20/18, at 11:53 a.m. SW-A stated the facility usually fills out a concern grievance form, or missing item form, and follow up that way, but she was unable to find one for R34's concern regarding her missing bra. SW-A stated she would interview R34 that day and follow-up. SW-A stated they had checked other resident rooms. SW-A stated they usually tell the resident the result. SW-A verified she did not find a grievance form pertaining to R34's missing bra. SW-A stated they might replace it if it had been stolen. SW-A stated she would check with R34 to determine if she had any other bras. SW-A stated R34 had not stayed out overnight outside of the facility, so the bra would have been lost at the facility.

On 6/21/18, at 10:55 a.m. R34 was observed sitting in the day room across from the nurse's station doing puzzles, and watching television. R34 did not have a bra on under her shirt, and a few staff stopped by to interact with her. R34 was taken to her room per her request by nursing assistant (NA)-A. R34 stated she did not have any bras and said the bra she bought and lost was the only bra she had. NA-A verified R34 did not have any bras at that time. R34 stated no one had talked to her this week about her missing bra.

On 6/21/18, at 11:08 a.m. R34 stated she felt uncomfortable without a bra and was embarrassed sometimes, especially when the male staff assisted her. R34 stated she was very

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F 585	Continued From page 26 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.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		7/20/18

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F 609	Continued From page 27 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to 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. R33's quarterly Minimum Data Set (MDS) dated 6/8/18, indicated R33 was cognitively intact, and required limited to moderate assistance with activities of daily living (ADLs). R33's care plan dated 2/1/18, indicated R33 was a vulnerable adult, and any situation identified as abuse or the potential for abuse would be reported per the facility protocol, and indicated staff were aware of R33's vulnerability. On 6/18/18, at 6:00 p.m. R33 was interviewed and stated a female staff had pulled up his pants too tight and it hurt. R33 stated he had told the identified staff member that it hurt, and had reported it to other staff. R33 stated he felt it was a purposeful act. 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	F 609	All residents of the facility had the potential to be affected by the violation. To prevent this from happening again, all staff were re-educated via "Friday Notes" on 6/22/2018 about timely reporting, also on 7/2/2018 at nurses meeting - nurses were re-educated on timely abuse reporting. A new form was made to track incidents for OHFC reporting that now includes the time of incident and times reported to administrator, DON & OHFC. To maintain compliance with F609 all staff will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later then 24hrs if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator or designee and OHFC. Administrator or designee will track all VA reports with the new form created to make sure that the facility has reported timely as required. Social Worker or designee will audit the form 2x/week x 4 weeks, then 3x/monthly x 2 months and then as need basis upon findings.Negative findings will be reported at the quarterly quality meetings. The facility is in full compliance with F609	

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F 609	Continued From page 28 submitted to the State Agency (SA) on 6/19/18, at 3:34 p.m. On 6/19/18, at 4:11 p.m. the director of nursing (DON) was interviewed and stated she had notified the administrator about R33's allegations of abuse immediately, implemented interventions to keep R33 safe, and talked to R33 about his concerns that morning. The DON stated the facility goes by the resident's perception, so it was reported to the SA. The DON stated since there was no serious injury, they had 24 hours to report it. The identified staff member was re-educated, and was not working with the resident at that time. On 6/19/18, at 4:58 p.m. the DON reviewed the reporting guidelines, and verified all abuse needed to be reported within 2 hours. R28's Admission Record printed 6/21/18, indicated R28's diagnoses included Alzheimer's disease and dementia. R28's care plan initiated 12/28/17, indicated R28 was a vulnerable adult, and any situation identified as abuse or potential abuse would be reported per facility protocol. R28's progress notes dated 5/14/18, at 8:00 a.m. indicated another resident was standing over R28 while she sat in a dining room chair in the hallway. The other resident pushed R28 on the shoulder and pulled on her elbow, and yelled at her to, "Get up out of the chair." R28 was confused, and asked why the other resident was pushing her. Staff intervened and no injuries were noted.	F 609	as of 7/10/2018	

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F 609	Continued From page 29 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. R12's Admission Record printed 6/21/18, indicated R12's diagnoses included dementia. R12's care plan initiated 4/6/18, indicated R12 had a cognitive impairment. R12's care plan directed staff to provide assistance with personal hygiene, toilet use and incontinent cares. An incident dated 3/30/18, at 10:30 p.m. indicated R12 was found with his arms crossed over his chest with a sheet tucked around his upper body, and dried feces on his hands, gown, legs, and sheets. A report for this incident was submitted to the SA on 4/4/18, at 10:16 a.m. more than 5 days after the alleged abuse occurred. On 6/21/18, at 4:27 p.m. the DON verified the allegations of abuse were reported late to the SA. The facility policy Abuse Prevention and Vulnerable Adult Reporting Plan dated 5/17, defined abuse as a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The facility policy directed staff to report suspected abuse within 2 hours to the administrator and SA.	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		7/13/18

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representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

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must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

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F 623	Continued From page 32 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Long Term Care Ombudsman received written notification of discharge to the hospital for 1 of 1 residents (R139) reviewed for hospitalization. Findings include: R139's Admission Record printed 6/19/18, indicated R139's diagnoses included congestive heart failure, gastrointestinal hemorrhage, atrial fibrillation (irregular heart beat), and dementia. R139's quarterly Minimum Data Set assessment dated 5/7/18, indicated R139 had been discharged with return anticipated on 5/7/18. R139's progress notes dated 5/7/18, indicated R139 was sent to the hospital and hospitalized on 5/7/18, following a sudden change in condition. R139's progress notes lacked documentation that the Ombudsman was notified regarding R139's hospitalization. R139's progress notes dated 5/10/18, indicated R139 had expired while in the hospital.	F 623	Social worker updated ombudsman's via written communication on 7/13/2018 regarding (R139) discharge to hospital. All residents of the facility have the potential to be affected by this violation. Social worker went back to April 1st, 2018 and updated ombudsman's via written communication any resident that was missed for notification. To prevent this from happening again, social worker was educated on notifying the ombudsman with written notification of transfers/discharges as required. To maintain compliance with F623 the social worker or designee will notify the ombudsman with written notification of transfers/discharges on a weekly basis. DON or designee will audit this weekly x 4 weeks, then monthly x 3 months and than as need basis upon findings. Negative findings will be reported at the quarterly quality meetings. The facility will be in full compliance with F623 as of 7/13/2018	

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F 623	Continued From page 33 On 6/19/19, at 1:09 p.m. the Ombudsman verified through email she did not get notified of R139's discharge to the hospital, or subsequent death. On 6/19/18, at 3:18 p.m. social worker (SW)-A stated she should notify the Ombudsman of hospital discharges, and stated she though she had called and left the ombudsman a voice message regarding R139's discharge. On 6/19/18, at 3:25 p.m. SW-A verified she did not notify the Ombudsman regarding R139's hospitalization. SW-A stated they did not have a policy for notification of the Ombudsman of a hospitalization, and stated she should follow the regulation.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		7/26/18

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F 657	Continued From page 34 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was revised to reflect a current pressure ulcer for 1 of 1 residents (R3) reviewed for pressure ulcers. Findings include: R3's Admission Record printed 6/20/18, indicated R3 was admitted on 7/10/14. The medical record revealed R3's diagnoses included dementia without behavioral disturbance, atrial fibrillation and hypertension. R3's quarterly Minimum Data Set (MDS) dated 4/2/18, indicated R3 had severe cognitive impairment. R3 care plan dated 4/3/18, indicated, "... resident has potential impairment to skin integrity r/t [related to] fragile skin, dementia with cognitive impairment ... MASD [moisture-associated skin damage] noted to intergluteal fold on 3/12/18 and resolved on 3/28/18." In addition, care plan dated 6/18/18, indicated, "The resident MASD will be healed by the review date..." However, the care plan lacked documentation that R3 had a current pressure ulcer.	F 657	Element #1: Resident R3's care plan was updated on 6/21/2018 to reflect the pressure ulcer Element#2: All residents of the facility had the potential to be affected by the violation. All residents care plans will be reviewed to make sure they are all updated. Element #3: To prevent this from happening again, nurse managers & MDS coordinator have been educated on updated residents plan of care as changes occur. Element #4: To maintain compliance with F657 the DON or designee will audit 4 care plans monthly x 3 months and than as need basis upon findings to ensure that any revisions that are needed have been completed. Negative findings will be reported at the quarterly quality meetings. Element #5: The facility will be in full compliance with F657 as of 7/13/2018	

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R3's Physician Order dated 5/22/18, directed Calazinc cream (topical moisture barrier cream) every shift for pressure ulcer. Apply topically to right buttock until resolved.

R3's progress note dated 5/21/18 at 12:12 p.m. revealed, "During resident shower nurses aide called writer to assess an open area on resident right buttock. Area measures 1.2 cm x 2.1 cm x less than 0.1 cm. [Centimeter] The wound bed is shiny pink granular tissue, and the peri wound in healthy, pink and blanchable..."

R3's progress note dated 5/23/18 at 3:47 p.m. indicated, " ... Area measures 1.2 cm x 2.1 cm x less than 0.1 cm. The wound bed is shiny pink granular tissue, and the peri wound in healthy, pink and blanchable. Treatment includes includes calazinc q shift..."

The physician assistant progress note dated 6/11/18 at 11:46 a.m. indicated, " ... does have a stag-able [sic] ulcer on her right buttock but it is resolving ... Area measures 1.2 cm x 2.1 cm x less than 0.1 cm. The wound bed is shiny pink granular tissue, and the peri wound in healthy, pink and blanchable. Treatment includes includes calazinc q [every]shift..."

R3's progress note dated 6/13/18 at 4:12 p.m. specified " ... Area measures 0.3 cm x 0.3 cm, and is a dry, lifted, dark brown scab. It still considered a stage two pressure area that is scabbed with a healing wound bed. The peri wound in healthy, pink and blanchable. Treatment includes includes calazinc q shift ..."

On 6/20/18 at 1:07 p.m. registered nurse (RN)-A

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F 657	Continued From page 36 verified R3's care plan lacked documentation of the pressure ulcer. RN-A stated, "Is my responsibility to update the care plan, and I missed it." The facility policy Care Plans, Comprehensive Person-Centered revised December 2016, directed, "13. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change..."	F 657		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		7/13/18

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F 726	Continued From page 37 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure licensed nursing staff demonstrated competency skills related to identifying changes in resident condition and timely notification of the physician when a change in condition was identified for 1 of 2 residents (R18) reviewed for notification of change in condition. Findings include: R18's Admission Record printed 6/21/18, included diagnoses of type two diabetes, dementia and anxiety. R18's quarterly Minimum Data Set (MDS) dated 5/3/18, indicated R18 had severely impaired cognition. The MDS further indicated R18 required extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and eating. The MDS indicated R18 did not walk, did not have a swallowing disorder, and received insulin injections on seven of seven days during the assessment period. R18's Order Review Report signed by the physician on 5/11/18, included orders to check R18's blood sugar four times a day for diabetes. The Facility's Standing orders signed 6/7/18, directed to notify the physician if two blood sugar	F 726	Element #1: The nurse that neglected to appropriately assess and update MD & family with condition change for resident R18 has been terminated as of 6/21/2018 Element #2: All other residents of the facility had the potential to be affected by the violation. Element #3: To prevent this from happening again, nurses were instructed thru shift report starting on 6/21/2018 to review the following 3 polices: 1)Change in resident's condition or status 2)Medication & treatment orders 3) Acute condition changes - clinical protocol. On 6/22/2018 in "Friday Notes" it was stated for nurses to review the above policies also. On 7/2/2018 a nurses meeting was held, and nurses again were educated on the above polices. Element #4: To maintain compliance with F726 the DON or designee will audit 2 residents weekly x 4 weeks and then 4 residents monthly x 3 months to ensure a change in condition has not been missed along with updating MD/NP and family. Negative findings will be reported at the quarterly Quality meetings Element #5: The facility will be in full compliance with F726 as of 7/13/2018	

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results are less than 70 in a 24 hour period and/or a change in condition. The Standing Orders further directed for blood sugars of 60 or below give 240 milliliters (ml) of 2% milk, skim milk, or orange juice with graham crackers, cheese or a half of a sandwich. Repeat blood sugar check 30 minutes later. For blood sugars of 50 and below if unable to swallow; give one tube of glucose gel and recheck the blood sugar in 15 minutes. If no change in blood sugar give another tube of glucose gel. Give up to 3 tubes waiting 15 minutes in between. If the resident was unable to swallow give Glucagon (glucose) 1 milligram (mg) intramuscularly (IM) and recheck the blood sugar in 15 minutes. If no increase in the blood sugar or the blood sugar continues to drop, contact the physician immediately.

R18's care plan revised on 4/14/18, indicated clinical monitoring for diabetes. Interventions directed to observe and report as needed any signs or symptoms of hypoglycemia (low blood sugar). Signs and symptoms included sweating, tremors, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, and staggered gait.

R18's Medication Administration Record (MAR) dated 5/18, indicated on 5/13/18, at 8:00 a.m. R18's blood sugar was 50, and at 12:00 p.m. R18's blood sugar was 59.

R18's progress note dated 5/13/18, at 2:45 p.m. indicated R18 had been lethargic all day, and was combative with cares. Many attempts were made to offer R18 fluids but R18 refused. R18 had not eaten, and pushed away staff's hands. R18's blood sugar was low in parameter. R18's family was present and requested R18 be sent to the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 39	F 726		

hospital. R18 was then sent to the hospital. The progress note lacked evidence of assessment, treatments or notification of the physician when R18's blood sugar levels were low.

On 6/19/18, at 10:49 a.m. R18's family representative (F)-A was interviewed, and stated on Mother's Day, R18's family came to the facility about noon. R18 had been incontinent of stool, and the family had to ask for R18 to be changed. R18 had not been dressed or washed, and smelled bad. F-A further stated R18's blood sugar was low, and R18 had to go to the hospital. F-A stated R18's blood sugar was 39 in the ambulance. F-A stated the facility did not catch the low blood sugar, the family did.

On 6/21/18, at 1:57 p.m. the director of nursing (DON) stated condition changes were often reported by the nursing assistant (NA), during report and by using the Stop and Watch forms. The nursing staff could call the DON or the RN managers to see what they need to do. In the afternoon, or on the weekend when there was not a supervisor present, the DON would encourage the nurses to call her, or the RN care manager. The DON stated nursing staff could also notify the physician or call 911, depending what was going on. The DON stated typically the facility does not have to send residents to the hospital due to a low blood sugar because it is taken care of at the facility. The DON stated staff were evaluated to assess their competencies, skill, and knowledge during orientation, with on-going training, and if there were any issues she would do some one-to-one training. The DON stated the nurse who was working with R18 the day her blood sugars were low and she was transported to the hospital, was new to the facility, and it was a busy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	C 06/21/2018

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F 726	Continued From page 40 morning medication pass. The nurse said she did give R18 some milk, but did not document it. R18 had been combative earlier and it was overwhelming for her. The DON stated the nurse was re-educated on standing orders, asking for help from the other nurse, calling the DON and calling the physician. The also nurse worked one on one with another nurse. Since R18 was alert, the DON would expect staff to give milk, recheck the blood sugar, check the standing orders and assess the resident's condition. R18 could have received Glucagon per standing orders. The facility's Nurse Orientation documentation indicated the nurse received orientation on updating the providers by telephone, facsimile or the rounding folder. The facility's Change in a Resident's Condition or Status policy dated 12/16, indicated the facility would promptly notify the resident, the attending physician and a representative of changes in the resident's medical or mental condition and or status.	F 726		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		7/13/18

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F 812	Continued From page 41 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure supplements were dated when thawed for 8 of 8 residents (R7, 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 dietary aide (DA)-A reported she stocked the supplements, and was not aware of how long they had been thawed. DA-A reported she did not know how long the supplements could be served once thawed. The Lyons Readycare Nutritional Product Line undated, under shelf life directed the product was good for no more than 14 days unopened.	F 812	Element #1: All mighty shakes were thrown out that were not dated in the fridge. Element #2: All resident who are ordered to have nutritional supplements had the potential to be affected by the violation. Element #3: To prevent this from happening again, the dietary manager educated dietary staff on proper food storage and labeling information along with a copy of the policy and procedure. Element #4: To maintain compliance with F812 the dietary manger or designee will audit food storage & labeling weekly x 4 weeks, then 3x/month x 2 months and then monthly thereafter. Negative findings will be reported at the quarterly Quality meetings. Element #5: The facility will be in full compliance with F812 as of 7/13/2018	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/13/18

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F 880	Continued From page 42 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 43 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control practices to prevent cross contamination during a glucometer check for 1 of 2 residents (R25) reviewed for blood glucose monitoring. In addition, the facility failed to ensure the Legionella policy and procedure provided guidance for management of suspected Legionella cases and testing criteria. This had the potential to affect all 37 residents who resided in the facility.	F 880	Element #1: Resident R25 was given his own glucometer to keep in his room on 6/21/2018. Element #2: All other diabetic residents who receive glucometer checks had the potential to be affected by the violation. Element #3: To prevent this from happening again the blood glucometer policy & procedure was updated and nurses were educated on it at the nurses meeting on 7/2/2018. They also tested out with cleaning a glucometer correctly.	

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F 880	Continued From page 44 Findings include: R25's Admission Record printed 6/21/18, indicated R25's diagnoses included diabetes mellitus type 2, and R25 was a carrier of methicillin resistant staphylococcus aureus (MRSA). 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 notes indicated R25 had an order to self check blood glucose four times daily with nursing staff. R25's Physician Orders directed blood sugar checks four times daily and at bedtime. On 6/18/18, at 3:53 p.m. registered nurse (RN)-B entered R25's room. R25 was on contact precautions for MRSA in a wound. RN-B sanitized her hands, and handed R25 the supplies to do his own blood glucose check with the facility glucometer. R25 cleansed his finger, poked his finger with the lancet, and obtained his blood sample. R25 placed the sample onto the test strip that had been placed in the glucometer, and removed the test strip after reading the result. RN-B gloved, cleansed the site for the injection of the insulin, injected the insulin, and picked the glucometer up from R25's tray table. RN-B removed her gloves, sanitized her hands, and carried the glucometer in her left hand. RN-B opened the medication cart with her right hand, and put the glucometer directly on the medication	F 880	Element#3a: A Policy and procedure was developed for Legionella Surveillance and Detection. The new policy for this will go into "Friday Notes" on July 13th for staff to be aware of the new policy. The Legionella water management policy was also updated. Element #4: To maintain compliance with F880 the nurse manager, DON or designee will audit 4 nurses monthly x 3 months then as need basis upon findings for correct procedure for Glucometer use & cleaning. Negative findings will be reported at the quarterly Quality meetings. Element #5: The facility will be in full compliance with F880 by 7/13/2018	

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F 880	Continued From page 45	F 880		

cart. RN-B then gloved, opened a purple Sani-wipe, cleansed the glucometer and wrapped it in a purple Sani-wipe, and placed it in a cup. RN-B stated the glucometer was a shared glucometer, and verified R25 was on contact precautions. RN-B verified R25 handled the glucometer, and she set the unclean glucometer directly on the medication cart. RN-B verified there was a risk for cross contamination, and stated she should have cleansed the glucometer before setting it on the medication cart. RN-B then wiped off the medication cart with a purple Sani-wipe.

On 6/21/18, at 3:45 p.m. the director of nursing (DON) verified there could be a risk of cross contamination with the unclean glucometer placed on the medication cart. The DON stated the facility was going to be looking into getting R25 his own personal glucometer.

The facility policy Assure Prism Blood Glucose Monitoring System Recommended Use and Cleaning undated, directed nursing to use a clean super Sani-cloth to clean and disinfect the glucometer, thoroughly wet the glucometer, lay the treated glucometer on paper towel and allow to remain wet for a full 2 minutes and let air dry.

The facility policy Water Management System undated, lacked guidance for management of suspected Legionella cases, and lacked testing criteria and parameters.

On 6/21/18, at 4:04 p.m. the director of nursing (DON) verified the policy did not address the management of suspected Legionella cases. The DON stated they would look further at the testing criteria and parameters for Legionella.

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	245454	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/20/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Sandstone Nursing Health Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Sandstone Nursing Health Care Center, is a 1-story building with a partial basement. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1988 an addition was constructed to the building that was determined to be of Type II(111) construction. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is fully fire sprinklered protected and also has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is Met.	K 000		

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

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

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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

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
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 6/18/18, through 6/21/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. H Complaint H5454010 was investigated and was substantiated. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the	2 265		7/13/18

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SANDSTONE HEALTH CARE CENTER	109 COURT AVENUE SOUTH SANDSTONE, MN 55072

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2 265	Continued From page 3 resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the physician was notified upon a change in condition for 2 of 4 residents (R18, R25) reviewed for notification of change. Findings include: R18's Admission Record printed 6/21/18, included diagnoses of type two diabetes, dementia and anxiety. R18's quarterly Minimum Data Set (MDS) dated 5/3/18, indicated R18 had severely impaired cognition. The MDS further indicated R18 required extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and eating. The MDS indicated R18 did not walk, did not have a swallowing disorder, and received insulin injections on seven of seven days during the assessment period. R18's Order Review Report signed by the physician on 5/11/18, included orders to check R18's blood sugar four times a day for diabetes. The Facility's Standing orders signed 6/7/18, directed to notify the physician if two blood sugar results are less than 70 in a 24 hour period and/or a change in condition. The Standing Orders further directed for blood sugars of 60 or below give 240 milliliters (ml) of 2% milk, skim milk, or orange juice with graham crackers, cheese or a half of a sandwich. Repeat blood sugar check 30	2 265	Corrected	

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2 265	Continued From page 4	2 265		

minutes later. For blood sugars of 50 and below if unable to swallow; give one tube of glucose gel and recheck the blood sugar in 15 minutes. If no change in blood sugar give another tube of glucose gel. Give up to 3 tubes waiting 15 minutes in between. If the resident was unable to swallow give Glucagon (glucose) 1 milligram (mg) intramuscularly (IM) and recheck the blood sugar in 15 minutes. If no increase in the blood sugar or the blood sugar continues to drop, contact the physician immediately.

R18's care plan revised on 4/14/18, indicated clinical monitoring for diabetes. Interventions directed to observe and report as needed any signs or symptoms of hypoglycemia (low blood sugar). Signs and symptoms included sweating, tremors, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, and staggered gait.

R18's Medication Administration Record (MAR) dated 5/18, indicated on 5/13/18, at 8:00 a.m. R18's blood sugar was 50, and at 12:00 p.m. R18's blood sugar was 59.

R18's progress note dated 5/13/18, at 2:45 p.m. indicated R18 had been lethargic all day, and was combative with cares. Many attempts were made to offer R18 fluids but R18 refused. R18 had not eaten, and pushed away staff's hands. R18's blood sugar was low in parameter. R18's family was present and requested R18 be sent to the hospital. R18 was then sent to the hospital. The progress note lacked evidence of assessment, treatments or notification of the physician when R18's blood sugar levels were low.

On 6/19/18, at 10:49 a.m. R18's family representative (F)-A was interviewed, and stated

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2 265	Continued From page 5 on Mother's Day, R18's family came to the facility about noon. R18 had been incontinent of stool, and the family had to ask for R18 to be changed. R18 had not been dressed or washed, and smelled bad. F-A further stated R18's blood sugar was low, and R18 had to go to the hospital. F-A stated R18's blood sugar was 39 in the ambulance. F-A stated the facility did not catch the low blood sugar, the family did. On 6/21/18, at 10:43 a.m. licensed practical nurse (LPN)-A stated if a resident had a condition change, LPN-A would assess the resident and let the registered nurse (RN) know. If it was during the weekend, LPN-A would notify the on-call supervisor. LPN-A would give the resident food or something to drink if they were coherent and then would monitor. LPN-A stated If the resident was not coherent, she would give glucose gel or IM glucose. LPN-A further stated the facility had standing orders to use, and they were to notify the on call physician. On 6/21/18, at 11:14 a.m. LPN-B stated if a resident had a change in condition, she would assess the resident, and let the RN know. If it was during the weekend, LPN-B would notify the on-call supervisor. LPN-B further stated if a resident had a low blood sugar, the facility had standing orders and she would follow the facility's protocol. LPN-B stated there was a list of on call physicians, and would call if needed. On 6/21/18, at 1:57 p.m. the director of nursing (DON) stated condition changes were often reported by the nursing assistant (NA), during report and by using the Stop and Watch forms. The nursing staff could call the DON or the RN managers to see what they need to do. In the afternoon, or on the weekend when there was not	2 265		

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2 265	Continued From page 6	2 265		

a supervisor present, the DON would encourage the nurses to call her, or the RN care manager. The DON stated nursing staff could also notify the physician or call 911, depending what was going on. The DON stated typically the facility does not have to send residents to the hospital due to a low blood sugar because it is taken care of at the facility. The DON stated staff were evaluated to assess their competencies, skill, and knowledge during orientation, with on-going training, and if there were any issues she would do some one-to-one training. The DON stated the nurse who was working with R18 the day her blood sugars were low and she was transported to the hospital, was new to the facility, and it was a busy morning medication pass. The nurse said she did give R18 some milk, but did not document it. R18 had been combative earlier and it was overwhelming for her. The DON stated the nurse was re-educated on standing orders, asking for help from the other nurse, calling the DON and calling the physician. The also nurse worked one on one with another nurse. Since R18 was alert, the DON would expect staff to give milk, recheck the blood sugar, check the standing orders and assess the resident's condition. R18 could have received Glucagon per standing orders. The DON further stated if those things would have been done, the outcome most likely would have been different.

The facility's Nursing Care of the Resident with Diabetes Mellitus policy dated 12/15, directed the severity of hypoglycemia was determined by a combination of blood sugar results and clinical symptoms. For residents who are symptomatic such as lethargy and drowsy and able to swallow, immediately give an oral form of rapidly absorbed glucose (four ounces of juice or five to six ounces of soda.) Recheck the blood sugar in 15 minutes.

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2 265	Continued From page 7 If indicated repeat the juice and recheck the blood sugar in 15 minutes. If no improvement notify the physician. The facility's Change in a Resident's Condition or Status policy dated 12/16, directed the facility would promptly notify the resident, the attending physician and a representative of changes in the resident's medical or mental condition and or status. R25's Admission Record printed 6/21/18, indicated R25's diagnoses included diabetes mellitus (DM) type 2 with other diabetic neurological complication, chronic kidney disease, and atherosclerotic heart disease. R25's admission MDS dated 5/10/18, indicated R25 was cognitively intact. R25's care plan dated 5/11/18, indicated R25 was to have blood sugar checks as ordered, and directed staff to observe and report any signs and symptoms of hyperglycemia (elevated blood sugars) or hypoglycemia. R25's signed Physician Orders dated 6/11/18, included orders for Novolog mix 70/30 suspension (fast-acting and intermediate-acting insulin for diabetes) 100 units subcutaneously (tissue under the skin) one time daily, 80 units subcutaneously one time daily, and 100 units subcutaneously in the morning. R25's Admission History and Physical dated 6/4/18, indicated R25's blood glucose readings had been in the 200s but were decreasing. The physician documented R25 had hyperglycemia, and insulin was being adjusted.	2 265		

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2 265	Continued From page 8 R25's Physician Orders dated 6/4/18, indicated R25 had an order to self check blood glucose four times daily with nursing staff. The orders directed to update the nurse practitioner (NP) if blood sugar was less than 75 or greater than 300. R25's Standing Orders dated 6/7/18, directed staff to notify the NP or physician if two blood glucose result were less than 70 or greater than 400 in a 24-hour period and/or condition change. If no condition change, notify the next business 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 11:44 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 4:29 p.m. 419 6/16/18, at 9:26 p.m. 522 6/16/18, at 10:41 p.m. 391 6/17/18, at 4:02 p.m. 486 6/17/18, at 8:53 p.m. 362 6/17/18, at 8:58 p.m. 362 6/18/18, at 12:10 p.m. 451 6/18/18, at 4:02 p.m. 356 6/19/18, at 7:44 p.m. 361 R25 had several readings over 300, and had occurrences of at least 2 readings over 400 within 24 hours. R25's progress notes dated 6/15/18, indicated R25 had an order for self check blood glucose four times daily with nursing staff, and update the NP if blood sugar is less than 75 or greater than 300.	2 265		

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2 265	Continued From page 9 R25's progress notes dated 6/16/18, at 9:26 p.m. indicated R25's blood sugar was 522, resident had eaten 3 puddings and an ice cream bar, and the nurse would follow up on the blood sugar. R25's progress notes dated 6/16/18, at 10:40 p.m. indicated R25's blood sugar was 391 at that time. R25's progress notes lacked documentation of notification of the physician or nurse practitioner of R25's elevated blood sugars and documentation of an assessment of R25's medical status or symptoms of hyperglycemia. On 6/21/18, at 12:12 p.m. the DON stated she would expect nursing to document elevated blood sugars, and notify the physician according to the physician orders and parameters. The DON stated the nurse should do an assessment, and document if the resident was experiencing any symptoms with blood sugars outside the parameter. The DON verified there was no documentation or indication if the physician or NP was notified of R25's elevated blood sugars. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure residents' physician was notified of a change in condition. 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.	2 265		

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2 265	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was revised to reflect a current pressure ulcer for 1 of 1 residents (R3) reviewed for pressure ulcers. Findings include: R3's Admission Record printed 6/20/18, indicated R3 was admitted on 7/10/14. The medical record revealed R3's diagnoses included dementia without behavioral disturbance, atrial fibrillation and hypertension. R3's quarterly Minimum Data Set (MDS) dated 4/2/18, indicated R3 had severe cognitive impairment.	2 570	Corrected	7/13/18

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2 570	Continued From page 11 R3 care plan dated 4/3/18, indicated, "... resident has potential impairment to skin integrity r/t [related to] fragile skin, dementia with cognitive impairment ... MASD [moisture-associated skin damage] noted to intergluteal fold on 3/12/18 and resolved on 3/28/18." In addition, care plan dated 6/18/18, indicated, "The resident MASD will be healed by the review date..." However, the care plan lacked documentation that R3 had a current pressure ulcer. R3's Physician Order dated 5/22/18, directed Calazinc cream (topical moisture barrier cream) every shift for pressure ulcer. Apply topically to right buttock until resolved. R3's progress note dated 5/21/18 at 12:12 p.m. revealed, "During resident shower nurses aide called writer to assess an open area on resident right buttock. Area measures 1.2 cm x 2.1 cm x less than 0.1 cm. [Centimeter] The wound bed is shiny pink granular tissue, and the peri wound in healthy, pink and blanchable..." R3's progress note dated 5/23/18 at 3:47 p.m. indicated, " ... Area measures 1.2 cm x 2.1 cm x less than 0.1 cm. The wound bed is shiny pink granular tissue, and the peri wound in healthy, pink and blanchable. Treatment includes includes calazinc q shift..." The physician assistant progress note dated 6/11/18 at 11:46 a.m. indicated, " ... does have a stag-able [sic] ulcer on her right buttock but it is resolving ... Area measures 1.2 cm x 2.1 cm x less than 0.1 cm. The wound bed is shiny pink granular tissue, and the peri wound in healthy, pink and blanchable. Treatment includes includes calazinc q [every]shift..."	2 570		

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2 570	Continued From page 12 R3's progress note dated 6/13/18 at 4:12 p.m. specified " ... Area measures 0.3 cm x 0.3 cm, and is a dry, lifted, dark brown scab. It still considered a stage two pressure area that is scabbed with a healing wound bed. The peri wound in healthy, pink and blanchable. Treatment includes includes calazinc q shift ..." On 6/20/18 at 1:07 p.m. registered nurse (RN)-A verified R3's care plan lacked documentation of the pressure ulcer. RN-A stated, "Is my responsibility to update the care plan, and I missed it." The facility policy Care Plans, Comprehensive Person-Centered revised December 2016, directed, "13. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change..." SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure care plans are revised to address the resident's current status and risks. 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		

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21025	Continued From page 13	21025		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure supplements were dated when thawed for 8 of 8 residents (R7, 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 dietary aide (DA)-A reported she stocked the supplements, and was not aware of how long they had been thawed. DA-A reported she did not know how long the supplements could be served once thawed. The Lyons Readycare Nutritional Product Line undated, under shelf life directed the product was good for no more than 14 days unopened. SUGGESTED METHOD FOR CORRECTION:	21025	Corrected	7/13/18

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21025	Continued From page 14 The dietary manager (DM) or designee could review and/or revise policies and procedures to ensure food is label with a date and left thawed per manufacture's directions to prevent food-borne illness. The DM or designee could educate the appropriate staff on the policies/procedures. The DM or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control practices to prevent cross contamination during a glucometer check for 1 of 2 residents (R25) reviewed for blood glucose monitoring. In addition, the facility failed to ensure the Legionella policy and procedure provided guidance for management of suspected Legionella cases and testing criteria. This had the potential to affect all 37 residents who resided in the facility.	21375	Corrected	7/13/18

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21375	Continued From page 15 Findings include: R25's Admission Record printed 6/21/18, indicated R25's diagnoses included diabetes mellitus type 2, and R25 was a carrier of methicillin resistant staphylococcus aureus (MRSA). 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 notes indicated R25 had an order to self check blood glucose four times daily with nursing staff. R25's Physician Orders directed blood sugar checks four times daily and at bedtime. On 6/18/18, at 3:53 p.m. registered nurse (RN)-B entered R25's room. R25 was on contact precautions for MRSA in a wound. RN-B sanitized her hands, and handed R25 the supplies to do his own blood glucose check with the facility glucometer. R25 cleansed his finger, poked his finger with the lancet, and obtained his blood sample. R25 placed the sample onto the test strip that had been placed in the glucometer, and removed the test strip after reading the result. RN-B gloved, cleansed the site for the injection of the insulin, injected the insulin, and picked the glucometer up from R25's tray table. RN-B removed her gloves, sanitized her hands, and carried the glucometer in her left hand. RN-B opened the medication cart with her right hand, and put the glucometer directly on the medication cart. RN-B then gloved, opened a purple	21375		

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21375	Continued From page 16 Sani-wipe, cleansed the glucometer and wrapped it in a purple Sani-wipe, and placed it in a cup. RN-B stated the glucometer was a shared glucometer, and verified R25 was on contact precautions. RN-B verified R25 handled the glucometer, and she set the unclean glucometer directly on the medication cart. RN-B verified there was a risk for cross contamination, and stated she should have cleansed the glucometer before setting it on the medication cart. RN-B then wiped off the medication cart with a purple Sani-wipe. On 6/21/18, at 3:45 p.m. the director of nursing (DON) verified there could be a risk of cross contamination with the unclean glucometer placed on the medication cart. The DON stated the facility was going to be looking into getting R25 his own personal glucometer. The facility policy Assure Prism Blood Glucose Monitoring System Recommended Use and Cleaning undated, directed nursing to use a clean super Sani-cloth to clean and disinfect the glucometer, thoroughly wet the glucometer, lay the treated glucometer on paper towel and allow to remain wet for a full 2 minutes and let air dry. The facility policy Water Management System undated, lacked guidance for management of suspected Legionella cases, and lacked testing criteria and parameters. On 6/21/18, at 4:04 p.m. the director of nursing (DON) verified the policy did not address the management of suspected Legionella cases. The DON stated they would look further at the testing criteria and parameters for Legionella. SUGGESTED METHOD FOR CORRECTION:	21375		

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21375	Continued From page 17 The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure glucometers are handled and cleaned properly to prevent cross contamination of blood-borne pathogens. The DON or diesignee could revise policies on Legionella. 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		7/13/18

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21426	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) baseline symptom screenings 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: Nursing assistant (NA)-B was hired on 5/15/18, and the first resident contact date was 5/17/18. NA-B lacked a baseline symptom screening that was signed and dated. NA-B had a two-step TST in 7/17 with negative, zero millimeter (mm) results. Registered nurse (RN)-B was hired on 3/12/18, and the first resident contact date was 3/13/18. RN-B had an undated baseline symptom screening. RN-B's first TST was given on 3/26/18, and read on 3/29/18, with negative, zero mm results. RN-B had a second TST given on 4/13/18, and was read on 4/15/18, with negative, zero mm results. RN-B lacked evidence of a negative baseline symptom screening and negative TST prior to fist contact. Dietary Aide (DA)-A was hired on 3/17/18, and fist contact date was 3/21/18. DA-A's baseline symptom screening was completed on 3/27/18. DA-A's first TST was given on 3/27/18 and read on 3/30/18 with negative, zero mm results. DA-A's second TST was given on 4/16/18, and read on 4/18/18, with negative, zero mm results.	21426	Corrected	

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21426	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 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. TIME PERIOD FOR CORRECTION: Twenty-one	21426		

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21426	Continued From page 20 (21) days.	21426		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by:	21800		7/13/18

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21800	Continued From page 21 Based on interview and document review, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice was given to 2 of 2 residents (R15, R33) whose Medicare A services ended, and they remained living in the facility. Findings include: R15's form CMS-20052 (Skilled Nursing Facility [SNF] Beneficiary Protection Notification Review), completed by the facility, revealed R15's Medicare Part A services started 2/12/18, and the last covered day of Part A service was 5/2/18. The form indicated the "Facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted." R15 remained in the facility after 5/2/18. Further record review revealed the facility had provided CMS-10123 Notice of Medicare Non-Coverage (NOMNC) however, a Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNF ABN, Form CMS-10055) was not provided. R33's form CMS-20052 completed by the facility, revealed R33's Medicare Part A services started 12/27/17, and the last covered day of Part A service was 1/29/18. The form indicated the "Facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted." R33 remained in the facility after 1/29/18. Further record review revealed the facility had no documentation that it provided CMS-10123 NOMNC. In addition, SNF ABN Form CMS-10055) was not provided. On 6/19/18, at 11:36 a.m. the facility social worker (SW)-A stated she did not know that two notices needed to be given. The SW stated she remembered giving the CMS-10123 NOMNC to R33, but could not find documentation showing	21800	Corrected	

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this had occurred. The SW confirmed she had not given the SNF-ABN CMS-10055 to either R15 or R33, as she did not know of this requirement.

The facility Resident Handbook dated 1/1/15, provided a brief overview of Medicare coverage, but does not identify the correct CMS requirements regarding Medicare Beneficiary notices.

A policy on provision of Medicare Beneficiary notices was requested but not received from the facility.

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:

R34's Admission Record printed 6/21/18, indicated R34's diagnoses included a mild cognitive impairment.

R34's quarterly Minimum Data Set (MDS) dated 6/10/18, indicated R34 was cognitively intact, understood others and was understood by others.

R34's significant change MDS dated 10/5/17, indicated it was very important to R34 to keep her things safe.

R34's care plan initiated 12/28/17, identified R34 as a vulnerable adult, and was at risk for abuse and exploitation. R34's care plan indicated R34 required assistance with dressing at times.

On 6/18/18, at 6:39 p.m. R34 stated she had

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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.

On 6/19/18, at 3:42 p.m. social worker (SW)-A stated she was aware of R34's missing bra, and stated they looked for it, but were unable to locate it.

On 6/20/18, at 11:53 a.m. SW-A stated the facility usually fills out a concern grievance form, or missing item form, and follow up that way, but she was unable to find one for R34's concern regarding her missing bra. SW-A stated she would interview R34 that day and follow-up. SW-A stated they had checked other resident rooms. SW-A stated they usually tell the resident the result. SW-A verified she did not find a grievance form pertaining to R34's missing bra. SW-A stated they might replace it if it had been stolen. SW-A stated she would check with R34 to determine if she had any other bras. SW-A stated R34 had not stayed out overnight outside of the facility, so the bra would have been lost at the facility.

On 6/21/18, at 10:55 a.m. R34 was observed sitting in the day room across from the nurse's station doing puzzles, and watching television. R34 did not have a bra on under her shirt, and a few staff stopped by to interact with her. R34 was taken to her room per her request by nursing assistant (NA)-A. R34 stated she did not have any bras and said the bra she bought and lost was the only bra she had. NA-A verified R34 did not have any bras at that time. R34 stated no one had talked to her this week about her missing bra.

On 6/21/18, at 11:08 a.m. R34 stated she felt

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21800	Continued From page 24 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 METHOD 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. The social worker (SW), director of nursing (DON) or designee could review and/or revise policies and procedures to ensure resident grievances, both voiced and in writing, are addressed in a timely and satisfactory manner. The SW, DON or designee could educate the appropriate staff on the policies/procedures. The SW, DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights	21805		7/13/18

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21805	Continued From page 25 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. 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. R33's quarterly Minimum Data Set (MDS) dated 6/8/18, indicated R33 was cognitively intact, and required limited to moderate assistance with activities of daily living (ADLs). R33's care plan dated 2/1/18, indicated R33 was a vulnerable adult, and any situation identified as abuse or the potential for abuse would be reported per the facility protocol, and indicated staff were aware of R33's vulnerability. On 6/18/18, at 6:00 p.m. R33 was interviewed and stated a female staff had pulled up his pants too tight and it hurt. R33 stated he had told the identified staff member that it hurt, and had reported it to other staff. R33 stated he felt it was a purposeful act.	21805	Corrected	

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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 submitted to the State Agency (SA) on 6/19/18, at 3:34 p.m.

On 6/19/18, at 4:11 p.m. the director of nursing (DON) was interviewed and stated she had notified the administrator about R33's allegations of abuse immediately, implemented interventions to keep R33 safe, and talked to R33 about his concerns that morning. The DON stated the facility goes by the resident's perception, so it was reported to the SA. The DON stated since there was no serious injury, they had 24 hours to report it. The identified staff member was re-educated, and was not working with the resident at that time.

On 6/19/18, at 4:58 p.m. the DON reviewed the reporting guidelines, and verified all abuse needed to be reported within 2 hours.

R28's Admission Record printed 6/21/18, indicated R28's diagnoses included Alzheimer's disease and dementia.

R28's care plan initiated 12/28/17, indicated R28 was a vulnerable adult, and any situation identified as abuse or potential abuse would be reported per facility protocol.

R28's progress notes dated 5/14/18, at 8:00 a.m. indicated another resident was standing over R28 while she sat in a dining room chair in the hallway. The other resident pushed R28 on the shoulder and pulled on her elbow, and yelled at her to, "Get up out of the chair." R28 was

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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.

R12's Admission Record printed 6/21/18, indicated R12's diagnoses included dementia.

R12's care plan initiated 4/6/18, indicated R12 had a cognitive impairment. R12's care plan directed staff to provide assistance with personal hygiene, toilet use and incontinent cares.

An incident dated 3/30/18, at 10:30 p.m. indicated R12 was found with his arms crossed over his chest with a sheet tucked around his upper body, and dried feces on his hands, gown, legs, and sheets. A report for this incident was submitted to the SA on 4/4/18, at 10:16 a.m. more than 5 days after the alleged abuse occurred.

On 6/21/18, at 4:27 p.m. the DON verified the allegations of abuse were reported late to the SA.

The facility policy Abuse Prevention and Vulnerable Adult Reporting Plan dated 5/17, defined abuse as a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The facility policy directed staff to report suspected abuse within 2 hours to the administrator and SA.

SUGGESTED METHOD FOR CORRECTION:

The director of nursing (DON) or designee could review and/or revise policies and procedures to

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21805	Continued From page 28 ensure allegations of abuse are reported to the State Agency timely. 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		