DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 11, 2024

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: August 21, 2024

Dear Administrator:

On September 10, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered

September 11, 2024

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

Re: Reinspection Results
Event ID: 70WS12

Dear Administrator:

On September 10, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 21, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 30, 2024

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: August 21, 2024

Dear Administrator:

On August 21, 2024, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 November 21, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by February 21, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@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
	245341	A. BUILDING _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	425 N ELM STREET SAUK CENTRE, MN 56378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/20/24 through 8/21/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53417140C (MN00105828)with a deficiency cited at F580. H53417189C (MN00104261) with NO citations issued. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §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	F 580		9/3/24

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

Electronically Signed | 09/03/2024

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

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F 580	Continued From page 1 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). §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:	F 580		

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F 580	Continued From page 2 Based on interview and document review, the facility failed to ensure resident's physician and responsible parties were notified in a timely manner for 1 of 1 resident (R1) reviewed for notification of change, who had increasing depression and had attempted to harm self. Findings include: A Vulnerable Adult Maltreatment Report dated 8/15/24, identified a report had been submitted for R1 which alleged resident's increasing depression, anxiety and attempt to strangle self with resident's nasal cannula (tubing attached to an oxygen source to deliver oxygen). These included increased comments voiced by R1 of telling family members she would rather die than stay "here", and on 8/13/24 that she was going to kill herself. On 8/13/24 at 9:55 p.m., licensed practical nurse (LPN)-A, documented in R1's medical record, "Resident stated she was going to kill herself and had her oxygen cannula wrapped around her neck. Staff removed the cannula around the neck. [Daughter] [family member (FM)-B], is currently visiting with her to help her sleep. Resident states she sees people outside her window as well." R1's admission Minimum Data Set (MDS) dated 6/27/24, identified R1 was moderately cognitively impaired, fed self after set up, but required extensive assistance for transfers, dressing, grooming and toileting. Further, the MDS documented diagnoses of chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, hypertension, cirrhosis, insulin dependent diabetes, major depression, and arthritis.	F 580	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 8/14/24 Suicide Policy was sent to ALL staff to review and sign off that they acknowledged understand. On 8/14/24 Licensed Nursing Staff received additional education stressing the importance of who needs to be notified, and the proper steps needed to ensure compliance with our suicide prevention policy. On 8/20/24 Vulnerable Adult Educare Education was sent out to all staff to complete within one week. 1:1 Coaching and Written Warnings for the staff that were working the day of the incident occurred. 8/27/24 Implemented Safety Plan prior to readmission to facility for R1. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. Our IDT Meeting Template now includes change of mood/suicidal ideations- During our IDT meeting, we will discuss anyone who may be at risk and proceed with social services designee to complete PHQ-9, Columbia Suicide Assessment. Shift Huddles- Discuss any changes with residents' mood/statements, etc..	

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F 580	Continued From page 3 R1's Care Area Assessment (CAA) for Cognitive Loss / Dementia, (from the admission MDS - dated 6/27/24), the facility documented the following: "Resident does have a diagnosis of cognitive decline as well as delirium. She also has mild recurrent major depressive disorder. In regard to respiratory, she has a diagnosis of chronic respiratory failure with hypoxia, chronic interstitial lung disease and a [history] of pneumonia. Resident also has liver cirrhosis and fatty liver disease. In regards to possible incontinence she has a diagnosis of bladder cancer ...". R1's Preadmission Screening and Resident Review (PASARR) dated 6/18/24, indicated R1 did not have any developmental disability, mental illness, suicidal ideation nor civil confinement for mental illness. R1's Clinical Resident Profile from her electronic medical records (print date of 8/21/24), listed R1's primary physician's name and contact number, as well as the contact information for three family members. The family members were listed in order of who was to be contacted first. R1's electronic medical record (EMR) from the time of LPN-A's entry on 8/13/24 at 9:55 p.m., lacked what interventions and safety measures the facility staff implemented, until 8/14/24 at 8:48 a.m., when social services assessed R1 and contacted resident's primary physician and daughter. In a telephone interview on 8/20/24 at 11:35 a.m., LPN-A stated one of the nursing assistant (NA)-A came up to her and stated R1 voiced she wanted to die. LPN-A suggested to the NA-A to bring R1	F 580	3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Suicide checklist for LPN/RN's on each medication cart to ensure they have a list of people to notify for any further occurrences. All staff had to review and sign off of the Suicide Prevention Policy and complete the Vulnerable Adult Educare Education Social Services Designee will complete PHQ-9 per MDS schedule. SSD will complete PHQ-9, if the residents score is 4 points or greater than last PHQ-9 score then SSD will reassess in 24 hours to confirm results. If second assessment confirms the change of score, the SSD will notify the RN Case Manager who will then update family, provider for any next steps whether it includes adjustments in medications, referral to psych. RN Case Manager will notify activity department to see if there are any additional programming such as 1:1's, Activities, etc. RN Case Manager and SSD will ensure that Careplans are up to date with any changes to current plan of care. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	

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F 580	Continued From page 4 out of her room to the day room and offer her coffee and a snack (the dayroom was across from the nurse station) to be more easily observed. At approximately 9:00 p.m., LPN-A stated the NA's (NA-A and NA-B) offered to get R1 ready for bed and R1 agreed. At approximately 9:30 p.m., LPN-A stated NA-A came to get her and said R1 was wrapping her nasal cannula around her neck. LPN-A entered the room noting NA-B holding R1's hands. LPN-A and NA's removed the cannula. While LPN-A was settling R1, she sent one of the NA's to call R1's daughter to see if she would come in and sit with R1 until she fell asleep. LPN-A stated family member (FAM)-B came in and sat with R1 until she fell asleep, leaving at 2:00 a.m. LPN-A verified neither she nor the NA informed family (FAM-A and FAM-B) of R1 wrapping the nasal cannula around her neck. Nor did the facility contact R1's primary physician or any on-call physicians. LPN-A stated the only conversation she had with FAM-B was FAM-B wanting the nurse to give R1 something to "knock her out". LPN-A stated they did not have any orders for that type of intervention. LPN-A was asked if during that conversation, had she mentioned to FAM-B about R1's incident. LPN-A stated: "no I didn't, she was kind a stand-off-ish." LPN-A stated from the time FAM-B left until morning staff came on (2:00 a.m. - 6:30 a.m.), she and the two NAs checked on R1 every 30 minutes, finding her sleeping until 6:30 a.m., when R1 requested to be toileted. During telephone interview on 8/20/24 at 11:51 a.m., the reporter (Report) stated the facility did not do enough to monitor R1's safety after finding R1 with the nasal cannula around her neck. Report stated the staff should have called the	F 580	Tracking sheet that correlates with the MDS schedule will be uploaded in Teams File that all IDT can access. This includes resident name, previous phq-9 score, and current phq-9 sore, change >4 Y/N, RN Case Manager Notification Y/N, Family Updated Y/N, Provider Notified Y/N, Activities Notified Y/N, Summary box to include any next steps that were taken such as medication changes, referral psych, etc.. DON will audit every Monday for compliance x 3 months (End Date Dec 2nd) 5.The date that each deficiency will be corrected. Suicide Policy Acknowledgment was due before the staff's next scheduled shift or no later than 8/21/24. DON will audit tracking sheet every Monday for compliance x 3 months (End Date Dec 2nd, 2024) 6.Documentation of completed audit forms and any follow up action taken from failed audits. The Goal is 100% Compliance after the 3 months with the intention being all current residents will have been included in this audit.	

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F 580	Continued From page 5 primary MD, on-call physician or brought her to the adjoining emergency room. An interview on 8/20/24 at 12:22 p.m., director of nursing (DON) stated after review of R1's EMR documentation during and after the incident, LPN-A lacked appropriate documentation to fully understand what occurred. DON verified the record lacked evidence that R1's primary physician / on call physician and family were contacted. During telephone interview on 8/20/24 at 2:05 p.m., FAM-A verified someone from the facility had called her around 9:30 p.m. on 8/13/24. However, she was only told that R1 was upset and wanted family to come in to visit. FAM-A stated she called FAM-B and requested FAM-B to go in and sit with R1. When asked if R1 would have the ability to follow through on harming herself, FAM-A only stated, R1's actions were not purposeful. An interview on 8/21/24 at 8:11 a.m., social work designee (SWD) stated she had not been informed of R1's attempt to harm self until the next morning during stand-up meeting with the interdisciplinary team. SWD performed a PHQ-9 (a depression assessment) and found R1's score greatly increased from admission over a month ago. SWD then performed a Columbia Suicide Assessment and found R1's score high. The facility then contacted R1's primary physician and FAM-A and transferred R1 to the adjoining emergency room for further assessment. During a telephone interview on 8/21/24 at 9:48 a.m., R1's primary physician (PP) verified neither he nor the on-call physician had been contacted	F 580		

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F 580	Continued From page 6 about R1's incident of wrapping the nasal cannula around her neck until the morning of 8/14/24. PP stated he has known R1 for about 24 years and did not feel she was capable of mentally or physical strength to following through on the act. PP stated the facility staff should have contacted him or the on-call physician immediately for orders and further assessment. PP mentioned labs and CT scans were completed the day prior and found R1's liver function and ammonia levels were elevated. PP stated this could be root cause for the change in mental disturbance and her actions. When asked about facility staff monitoring R1 only every 30 minutes from 2:00 a.m. until 6:30 a.m., PP responded "at least they did that." On 8/21/24, between 10:07 a.m. and 10:18 a.m., attempted to make contact with the two NAs (NA-A and NA-B) on the relief shift of 8/13/24, and the two NAs (NA-C and NA-D) on the night shift (scheduled from 8/13/24 until the morning of 8/14/24), receiving no return calls or messages. During an interview on 8/21/24 at 11:03 a.m., the facility administrator stated during general orientation all staff were educated in Vulnerable Adult regulations. In that education suicide was briefly discussed. Since this incident, all staff were provided copies of the facility's policy on Suicide Prevention. Furthermore, all staff have been assigned an online course in EDUCARE on Vulnerable Adult with a section on suicide prevention. Staff are to have it completed by Wednesday August 28, 2024. In review of the facility's policy, entitled: Suicide Prevention (effective date 01/2024) indicated in the following sections:	F 580		

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F 580	Continued From page 7 "A. Staff will notify Social Services of a resident making suicidal comments. If Social Services is not available, will notify the charge nurse." "D. Social Services and/or the nurse will document investigation with the resident in the progress notes section of the medical record." "E. If a resident is found to be actively suicidal, with the intent to harm self and meaningful plan the resident will not be left unattended." "G. The resident's provider or provider [on-call] will be notified of situation, provider orders obtained as to what staff should do for resident. Orders will be followed." "I. Responsible party of resident will be updated on resident's situation."	F 580		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 30, 2024

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

Re: State Nursing Home Licensing Orders
Event ID: 70WS11

Dear Administrator:

The above facility was surveyed on August 20, 2024 through August 21, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@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
	00640	A. BUILDING: _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTF	425 N ELM STREET SAUK CENTRE, MN 56378

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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: On 8/20/24 through 8/21/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H53417140C (MN00105828) with a licensing order issued at MN Rule 4658.0085 A-E H53417189C (MN00104261) with NO licensing order issued. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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.	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;	2 265		9/4/24

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2 265	Continued From page 3 D. a decision to transfer or discharge the 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 resident's physician and responsible parties were notified in a timely manner for 1 of 1 resident (R1) reviewed for notification of change, who had increasing depression and had attempted to harm self. Findings include: A Vulnerable Adult Maltreatment Report dated 8/15/24, identified a report had been submitted for R1 which alleged resident's increasing depression, anxiety and attempt to strangle self with resident's nasal cannula (tubing attached to an oxygen source to deliver oxygen). These included increased comments voiced by R1 of telling family members she would rather die than stay "here", and on 8/13/24 that she was going to kill herself. On 8/13/24 at 9:55 p.m., licensed practical nurse (LPN)-A, documented in R1's medical record, "Resident stated she was going to kill herself and had her oxygen cannula wrapped around her neck. Staff removed the cannula around the neck. [Daughter] [family member (FM)-B], is currently visiting with her to help her sleep. Resident states she sees people outside her window as well." R1's admission Minimum Data Set (MDS) dated 6/27/24, identified R1 was moderately cognitively impaired, fed self after set up, but required	2 265	*Corrected* Intended Plan of Correction 9/23/24	

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2 265	Continued From page 4 extensive assistance for transfers, dressing, grooming and toileting. Further, the MDS documented diagnoses of chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, hypertension, cirrhosis, insulin dependent diabetes, major depression, and arthritis. R1's Care Area Assessment (CAA) for Cognitive Loss / Dementia, (from the admission MDS - dated 6/27/24), the facility documented the following: "Resident does have a diagnosis of cognitive decline as well as delirium. She also has mild recurrent major depressive disorder. In regard to respiratory, she has a diagnosis of chronic respiratory failure with hypoxia, chronic interstitial lung disease and a [history] of pneumonia. Resident also has liver cirrhosis and fatty liver disease. In regards to possible incontinence she has a diagnosis of bladder cancer ...". R1's Preadmission Screening and Resident Review (PASARR) dated 6/18/24, indicated R1 did not have any developmental disability, mental illness, suicidal ideation nor civil confinement for mental illness. R1's Clinical Resident Profile from her electronic medical records (print date of 8/21/24), listed R1's primary physician's name and contact number, as well as the contact information for three family members. The family members were listed in order of who was to be contacted first. R1's electronic medical record (EMR) from the time of LPN-A's entry on 8/13/24 at 9:55 p.m., lacked what interventions and safety measures the facility staff implemented, until 8/14/24 at 8:48 a.m., when social services assessed R1 and	2 265		

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2 265	Continued From page 5 contacted resident's primary physician and daughter. In a telephone interview on 8/20/24 at 11:35 a.m., LPN-A stated one of the nursing assistant (NA)-A came up to her and stated R1 voiced she wanted to die. LPN-A suggested to the NA-A to bring R1 out of her room to the day room and offer her coffee and a snack (the dayroom was across from the nurse station) to be more easily observed. At approximately 9:00 p.m., LPN-A stated the NA's (NA-A and NA-B) offered to get R1 ready for bed and R1 agreed. At approximately 9:30 p.m., LPN-A stated NA-A came to get her and said R1 was wrapping her nasal cannula around her neck. LPN-A entered the room noting NA-B holding R1's hands. LPN-A and NA's removed the cannula. While LPN-A was settling R1, she sent one of the NA's to call R1's daughter to see if she would come in and sit with R1 until she fell asleep. LPN-A stated family member (FAM)-B came in and sat with R1 until she fell asleep, leaving at 2:00 a.m. LPN-A verified neither she nor the NA informed family (FAM-A and FAM-B) of R1 wrapping the nasal cannula around her neck. Nor did the facility contact R1's primary physician or any on-call physicians. LPN-A stated the only conversation she had with FAM-B was FAM-B wanting the nurse to give R1 something to "knock her out". LPN-A stated they did not have any orders for that type of intervention. LPN-A was asked if during that conversation, had she mentioned to FAM-B about R1's incident. LPN-A stated: "no I didn't, she was kind a stand-off-ish." LPN-A stated from the time FAM-B left until morning staff came on (2:00 a.m. - 6:30 a.m.), she and the two NAs checked on R1 every 30 minutes, finding her sleeping until 6:30 a.m., when R1 requested to be toileted.	2 265		

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2 265	Continued From page 6 During telephone interview on 8/20/24 at 11:51 a.m., the reporter (Report) stated the facility did not do enough to monitor R1's safety after finding R1 with the nasal cannula around her neck. Report stated the staff should have called the primary MD, on-call physician or brought her to the adjoining emergency room. An interview on 8/20/24 at 12:22 p.m., director of nursing (DON) stated after review of R1's EMR documentation during and after the incident, LPN-A lacked appropriate documentation to fully understand what occurred. DON verified the record lacked evidence that R1's primary physician / on call physician and family were contacted. During telephone interview on 8/20/24 at 2:05 p.m., FAM-A verified someone from the facility had called her around 9:30 p.m. on 8/13/24. However, she was only told that R1 was upset and wanted family to come in to visit. FAM-A stated she called FAM-B and requested FAM-B to go in and sit with R1. When asked if R1 would have the ability to follow through on harming herself, FAM-A only stated, R1's actions were not purposeful. An interview on 8/21/24 at 8:11 a.m., social work designee (SWD) stated she had not been informed of R1's attempt to harm self until the next morning during stand-up meeting with the interdisciplinary team. SWD performed a PHQ-9 (a depression assessment) and found R1's score greatly increased from admission over a month ago. SWD then performed a Columbia Suicide Assessment and found R1's score high. The facility then contacted R1's primary physician and FAM-A and transferred R1 to the adjoining	2 265		

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2 265	Continued From page 7 emergency room for further assessment. During a telephone interview on 8/21/24 at 9:48 a.m., R1's primary physician (PP) verified neither he nor the on-call physician had been contacted about R1's incident of wrapping the nasal cannula around her neck until the morning of 8/14/24. PP stated he has known R1 for about 24 years and did not feel she was capable of mentally or physical strength to following through on the act. PP stated the facility staff should have contacted him or the on-call physician immediately for orders and further assessment. PP mentioned labs and CT scans were completed the day prior and found R1's liver function and ammonia levels were elevated. PP stated this could be root cause for the change in mental disturbance and her actions. When asked about facility staff monitoring R1 only every 30 minutes from 2:00 a.m. until 6:30 a.m., PP responded "at least they did that." On 8/21/24, between 10:07 a.m. and 10:18 a.m., attempted to make contact with the two NAs (NA-A and NA-B) on the relief shift of 8/13/24, and the two NAs (NA-C and NA-D) on the night shift (scheduled from 8/13/24 until the morning of 8/14/24), receiving no return calls or messages. During an interview on 8/21/24 at 11:03 a.m., the facility administrator stated during general orientation all staff were educated in Vulnerable Adult regulations. In that education suicide was briefly discussed. Since this incident, all staff were provided copies of the facility's policy on Suicide Prevention. Furthermore, all staff have been assigned an online course in EDUCARE on Vulnerable Adult with a section on suicide prevention. Staff are to have it completed by Wednesday August 28, 2024.	2 265		

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2 265	Continued From page 8 In review of the facility's policy, entitled: Suicide Prevention (effective date 01/2024) indicated in the following sections: "A. Staff will notify Social Services of a resident making suicidal comments. If Social Services is not available, will notify the charge nurse." "D. Social Services and/or the nurse will document investigation with the resident in the progress notes section of the medical record." "E. If a resident is found to be actively suicidal, with the intent to harm self and meaningful plan the resident will not be left unattended." "G. The resident's provider or provider [on-call] will be notified of situation, provider orders obtained as to what staff should do for resident. Orders will be followed." "I. Responsible party of resident will be updated on resident's situation." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement measure to ensure timely notification to physicians. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure physician notification is performed as appropriate and in a timely manner. The facility should perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement.	2 265		

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2 265	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 265		