

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered February 22, 2022

Administrator Sandstone Health Care Center 109 Court Avenue South Sandstone, MN 55072

RE: CCN: 245454 Cycle Start Date: January 13, 2022

Dear Administrator:

On February 22, 2022, 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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 24, 2022

Administrator Sandstone Health Care Center 109 Court Avenue South Sandstone, MN 55072

RE: CCN: 245454 Cycle Start Date: January 13, 2022

Dear Administrator:

On January 13, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900 Email: <u>susan.frericks@state.mn.us</u> Mobile: (218) 368-4467

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 April 13, 2022 (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 July 13, 2022 (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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

Feel free to contact me if you have questions.

Sincerely,

Ç, >

Joanne Simon, Enforcement Specialist Minnesota Department of Health 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

	-					-	APPROVED
		& MEDICAID SERVICES					<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	CON	E SURVEY IPLETED
		245454	B. WING				C 13/2022
NAME OF F	PROVIDER OR SUPPLIER	•		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
CANDOT		CENTER			109 COURT AVENUE SOUTH		
SANDST	ONE HEALTH CARE	CENTER		\$	SANDSTONE, MN 55072		
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F 000	INITIAL COMMENT	ſS	FC	000			
	survey was conduc was found to be NC requirements of 42	13/22, a standard abbreviated ted at your facility. Your facility OT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.					
	The following comp SUBSTANTIATED:	laints were found to be					
	H5454020C(MN79 at F745, and	9279), with a deficiency cited					
	AND						
	SUBSTANTIATED: H5454021C (MN76	laints were found to be H5454019C (MN79872) and 155), but NO deficiencies ctions taken by the facility prior					
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 745 SS=D	onsite revisit of you validate that substa regulations has bee Provision of Medica	acceptable electronic POC, an r facility may be conducted to intial compliance with the en attained. ally Related Social Service	F 7	745	5		2/11/22
	§483.40(d) The fac	ility must provide ocial services to attain or					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						02/02/2022

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

PRINTED: 02/03/2022

		& MEDICAID SERVICES	1				0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ()	COMF	E SURVEY PLETED	
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NAME OF I	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
SANDST	ONE HEALTH CARE	CENTER		109 COURT AVENUE SOUTH SANDSTONE, MN 55072				
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F 745	Continued From pa	ige 1	F 7	45				
	and psychosocial w This REQUIREMEI by: Based on observar review, the facility f related social servic include the establis care plan and infor- verbalizations of su self-harm, for 1 of 2 behavioral concern Findings include: R3's Admission Re R3's diagnoses inc system related to a bipolar disorder. R3's admission Mir 12/6/22, indicated F no signs or sympto did not display any symptoms of depre- down, depressed, of assessment period concentrating on th had no pain at the was able to commu- others, and was un R3's care plan initia was at risk for psyce restrictions related R3 had the potentia staff and other male	st practicable physical, mental vell-being of each resident. NT is not met as evidenced tion, interview and document ailed to ensure medically ces and care was provided to shment of a comprehensive ming the provider of nicidal ideation and wishes for 2 residents (R3) reviewed for s. cord printed 1/13/22, indicated luded degeneration of nervous lcohol, anxiety disorder, and nimum Data Set (MDS) dated R3 was cognitively intact, had ms of delirium or psychosis, behaviors and had minimal ession, which included feeling or hopeless one day during the , and having trouble ings. R3's MDS indicated R3 time of the assessment, and unicate clearly, understood derstood by others. ated 11/24/21, indicated R3 chosocial well-being due to to COVID-19; and indicated al to be verbally aggressive to e resident related to poor gnitive issues, and was at risk			R3 verbally expressed suicidal thoug to staff. Despite implementation of immediate safety actions, care facility failed to complete appropriate care planning and notifications to provider responsible parties. All residents with suicidal ideation have the potential to affected by a deficient practice in this area. No additional residents identifier risk at this time. Suicide threats polic reviewed and revised as needed. Education provided to all nursing stat suicidal ideation policy and correct fo up procedures. DON or designee to complete random audits of documen and care plans to ensure appropriate notifications and interventions are in as follows: 3x/week for 1 month, 1x/v for 1 month, 2x/month for 1 month, a monthly thereafter. Audit result will be brought to QAPI Committee for revie and further recommendations	y staff r and o be s ed at y ff on ollow tation place week and e		

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	-	AND HUMAN SERVICES			FORM	02/03/2022 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATI COM	E SURVEY PLETED
		245454	B. WING			C 13/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER		109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 745	at risk to making ot lacked identification ideation and actions risks related to suic and interventions to of suicidal ideation may indicate suicida R3's nursing assista included intervention directed staff to do when R3 got loud a room, shut the door and if disoriented to he is and R3's sweat ladies and men that guide lacked intervention for verbalizations of self-harm. R3's Order Review directed monitoring restlessness (agitat kicking, cussing, ele psychosis, aggress any were noted, to progress notes eve monitoring for suicid R3's hospital history indicated R3 had a stress disorder (PT R3's electronic med R3 was seen at the (NP) on 11/26/21, 1 (documented R3 had yelling and mean be	hers fearful. R3's care plan of R3's history of suicidal s, recent verbalizations and oddress R3's verbalizations or self-harm, or behaviors that al ideation or self-harm. ant care guide dated 1/13/22, ons to ensure R3's safety and hourly activity checks, and and swore, to bring him to his r and talk to him at eye level, o place, remind him of where aring could frighten the elderly t lived in the facility. R3's care entions to ensure R3's safety f suicidal ideation and Report dated 1/13/22, for the following behaviors: tion), increase in complaints, opement, hallucinations, ion and refusal of cares, and if document in nurses notes and ry shift. R3's orders lacked dal ideation or self-harm. y and physical dated 11/2/21, history of post-traumatic	F 74	5		

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		AND HUMAN SERVICES				FORM	02/03/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·	IPLE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER		109 COURT AVENUE SOUTH SANDSTONE, MN 55072			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 745	emergency departm had improved beha days), 12/21/21 (no legs, history of PTS yelling and mean be residents), and 1/4/ for NP to see R3 re related to very disru- behaviors to staff a dose of an antianxin night). R3's NP visi mood and behavior changes. R3's NP she had been notifi- suicidal ideation an address R3's safety or self-harm. A review of R3's pro 1/13/22, indicated F verbalizations regan self-harm: -On 12/13/21, at 1:3 indicated R3 had be attempted to open to slammed it around, and became louder attempted. R3 was and one-to-one atte concern about his f "I might as well be of Tylenol for leg pain. any indication of welf an RN, DON, socia R3's progress notes	age 3 nent for pain in his legs, and wior in the previous couple of oted pain and numbness to SD, R3 had very disruptive, ehaviors to staff and other (22 (noted nursing's request egarding mood and behaviors uptive, yelling and mean nd other residents, requiring a ety medication the previous it notes addressed pain and concerns with medication visit notes lacked indication ed of R3's verbalizations of d self-harm, and did not y in regards to suicidal ideation ogress notes from 11/26/21 to R3 made the following rding suicidal ideation or 34 p.m. R3's progress note een very agitated that morning, the medication cart and , was continuously swearing, when redirection was removed from the situation ention provided. R3 expressed family being dead and stated, dead." R3 was administered . R3's progress notes lacked nether interventions were R3's safety, whether R3's f-harm was communicated to I services, or provider/NP. s lacked documentation w-up to R3's verbalizations of	F 74	15			

Facility ID: 00452

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 02/03/2022 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DAT CON	TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER			09 COURT AVENUE SOUTH ANDSTONE, MN 55072		
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F 745	self-harm. R3's pro of any psychosocia address R3's emoti -On 12/17/21, at 2:3 into the dining room wanting to harm hir been bothering me, it was amputated. If a log and a knife ar been given Tylenol on the phone about progress notes lack interventions were if whether R3's verbal communicated to a provider/NP. R3's p documentation regaverbalizations of se lacked evidence of were provided to ac distress. -On 12/22/21, at 3:3 could put a bullet to notes lacked any in interventions were if whether R3's suicid to an RN, DON, soor R3's progress notes regarding any follow suicidal ideation. evidence of any psy provided to address -On 12/23/21, at 6:4 going to lose his ho and had some lega	bgress notes lacked evidence I services were provided to onal distress. 32 a.m. R3 was up and going n, and was heard to verbalize nself and stated, "My leg has I have a lot of pain and I wish I will amputate it myself, I need ad I will cut it off." Resident had earlier. R3 was heard talking amputating his leg. R3's ted any indication of whether nitiated to ensure R3's safety, lization of self-harm was n RN, DON, social services, or orogress notes lacked arding any follow-up to R3's If-harm. R3's progress notes any psychosocial services diress R3's emotional 50 a.m. R3 stated "I wish I my brain." R3's progress	F 7	745			

Facility ID: 00452

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		AND HUMAN SERVICES			FORM	02/03/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245454	B. WING			C 13/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER		109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
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F 745	R3's progress note practical nurse (LPI and informed R3 sh him. R3 stated he v to him and would lik down and listen to h progress notes lack interventions were in whether R3's suicid to an RN, DON, so R3's progress notes regarding any follow suicidal ideation oth 12/24/21, as a late indicated social ser facility for inpatient lacked evidence of chaplain services w emotional distress. A review of R3's pro 1/13/22, further rev episodes of verbal swearing/vulgar lan verbal threatening of progress notes lack psychosocial service R3's emotional dist behaviors, other tha as a late entry for 1 services placed a c inpatient therapy. On 1/12/22, at 2:41 in pain due to neuro this day. R3 stated pain and would rath very agitated, his fa	indicated the licensed N) consoled and calmed R3 he was there all day to listen to would like a chaplain to listen ke someone who could sit him to help lift his spirits. R3's ked any indication of whether initiated to ensure R3's safety, dal ideation was communicated cial services, or provider/NP. s lacked documentation w-up to R3's verbalizations of her than documentation on entry for 12/22/21, that vices placed a call to another therapy. R3's progress notes any psychosocial services or vere provided to address R3's	F 74	5		

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		AND HUMAN SERVICES				FORM	02/03/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245454	B. WING				C 13/2022
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
SANDST	ONE HEALTH CARE	CENTER			109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 745	lucky ones." R3 de confrontations with along fine with staff his voice at others of room. R3 stated he past but had no pla of the interview. On 1/12/22, at 3:02 (RD), stated she ha services tasks, and talked about his fee stated they were try would be more app him with psychologi director of nursing (him more and had I him. The RD stated others and he was place. The RD stated others and he was place. The RD stated R3, keep him away have moved him to bathroom. The RD down, and his outbu RD stated R3 had a with other residents was coming to help needed to "streamli plan. On 1/12/22, at 3:28 were currently trying appropriate mental scheduled a therap DON verified R3 ha like to shoot himsel that out. The DON se expresses suicidal	ge 6 nied that he had any other residents, stated he got , and stated he did not raise or swear when outside his e has attempted suicide in the n to commit suicide at the time p.m. rehabilitation director ad been helping out with social stated R3 had more recently lings and his past. The RD ving to find another facility that ropriate for R3 and would help ical services and stated the (DON) had been working with been trying to find a place for I R3's behaviors impacted unpredictable and all over the ed they would try to re-direct from others when upset, and a private room with a private stated R3 usually would calm ursts had been decreasing. a couple of verbal altercations 5. RD stated the ombudsman with R3 and stated they ine" as a team to develop a	F	745			

Facility ID: 00452

If continuation sheet Page 7 of 12

		AND HUMAN SERVICES					FORM	02/03/2022 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	0	(X3) DATI COM	0938-0391 E SURVEY PLETED
		245454	B. WING					C 13/2022
NAME OF	PROVIDER OR SUPPLIER	-		S	REET ADDRESS, CITY, STATE, ZIF	, CODE		
SANDST	ONE HEALTH CARE	CENTER			9 COURT AVENUE SOUTH ANDSTONE, MN 55072			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	<	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 745	don't have anything and make time for t his guardian to caln did not need to do s was always out and safety checks and c on a case-by-case was new, so they w DON stated R3 had which to commit su a lot of one-to-one if frequently, and his DON stated R3 had distant past when h On 1/12/22, at 4:45 suicidal ideation ha should have been. On 1/13/22, at 10:3 suicidal ideation an care planned, DON R3 every 15-30 mir expressing suicidal DON stated she ha questions regarding incidents. On 1/13/22, at 10:4 (NA)-A, stated when he wanted to cut his not heard that R3 h dead. NA-A stated him to his room bed residents, they chec open. On 1/13/22, at 11:1	ge 7 to follow through with suicide, them. For R3, it helped to call in down. The DON stated they safety checks on him, as he l about, and the frequency of other interventions would be situation. The DON stated R3 rere getting to know him. The d not expressed a plan by icide. The DON stated R3 got interactions, saw the provider pain was addressed. The d attempted suicide in the re had a lot of trauma. p.m. the DON verified R3's d not been care planned and it 5 a.m. the DON verified R3's d self-harm, had not yet been stated they should monitor nutes when he wass upset or ideation or self-harm. The s heard staff asking him g how he was following 7 a.m. nursing assistant in R3 was upset and in pain, s leg off. NA-A stated she had ad said he would rather be when R3 was upset, they took cause he would scare other cked on him and left the door	F 7	45				

		AND HUMAN SERVICES				FORM	02/03/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
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SANDST	ONE HEALTH CARE (CENTER			09 COURT AVENUE SOUTH ANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	take R3 to his room de-escalate the situ frequently to make On 1/13/22, at 11:24 (RN)-A stated he has rather be dead. RN- R3 doesn't have a p around him to hurt I objects. RN-A state put on safety check then every 15 minut checks. On 1/13/22, at 11:33 been very upset wit nurses had said he being notified of oth ideation. The NP st R3's past suicidal a doing what they nee On 1/13/22, at 11:34 (LPN)-A, stated she wished he were dea upset with his family she was made awa expressing the wish treatment administr him every shift. LPN threatening or in an remove him from th resident's safety. On 1/13/22, at 1:18 staff receive PTSD remember if they has	ad. NA-B stated she would n, talked to him, tried to uation, and they check on R3	F 7	245			

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		AND HUMAN SERVICES				FORM	02/03/2022 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER			109 COURT AVENUE SOUTH SANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	been made aware of verbalizations of se 1/12/22. The admin documentation rega follow up following l ideation, or that psy provided. The admin ideation and though been care-planned, been updated with of psychosocial service The administrator fit actual social service one, and had been in Moose Lake. The and certified occupa assisting with socia mostly doing the pa services. On 1/13/22, at 2:42 a link with another of staff who have help MDS and paperwor families and residen frequently. The RD for a resident as a t team, so all care ar The RD stated they psychological service On 1/13/22, at 2:27 provider should be regarding suicidal in regarding self-harm The facility job deso	of R3's suicidal ideation or If-harm until the afternoon of histrator verified there was no arding notification of the NP, R3's incidents of suicidal ychosocial services were inistrator verified R3's suicidal hts of self-harm should have each occurrence, and the provider should have each occurrence, and the stated they did not have es staff, but were trying to get consulting with a psychologist a administrator stated the RD ational therapist aid, were a services, but had been aperwork aspects of social T p.m. the RD stated they have clinic with a social worker and bed her with training on the rk. The RD stated she knew ints well, and worked with them stated they set up resources team and do everything as a teas or needs are covered. T have been trying to get ces in house. T p.m. DON verified R3's notified of statements deation or verbalization n.	F	745			

If continuation sheet Page 10 of 12

		& MEDICAID SERVICES				0		0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION			E SURVEY PLETED
							(С
		245454	B. WING				01 /′	13/2022
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP (CODE		
SANDST	ONE HEALTH CARE	CENTER			COURT AVENUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETIO DATE
F 745		-	F 7	45				
	service information	staff, pertinent resident social , ent with adjustment to the						
	facility and maintain	ning periodic resident contacts, services plans of care and						
	follow-up progress -acting as a resider	notes, nt advocate,						
	needed,	ng services to resident when appropriate resources.						
	Resident's Condition directed the nurse of physician with a sign	nd procedure for Change in a on or Status, effective 10/21, to notify the resident's gnificant change in the emotional or mental condition.						
	Assessment, Interv 12/16, directed nur document, and info	nd procedure for Behavioral vention and Monitoring revised sing staff to "identify, vrm the physician about						
	individual's mental " The facility poli directed the interdis	arding changes in an status, behavior, and cognition cy and procedure further sciplinary team (IDT) to e new or changing behavioral						
	address potential c the facility policy din behavioral symptor	underlying causes, and ontributing factors. In addition, rected the IDT to, "evaluate ns in residents to determine						
	safety risk to the re care accordingly.	sident and develop a plan of Safety strategies will be						
	the resident and oth would monitor the r	hers from harm." The IDT resident's progress with until stable; and document any						
	the degree of seven safety risk to the re- care accordingly. S implemented imme the resident and oth would monitor the r impaired behavior	rity, distress and potential sident and develop a plan of Safety strategies will be ediately if necessary to protect hers from harm." The IDT resident's progress with						

If continuation sheet Page 11 of 12

		AND HUMAN SERVICES				FORM	02/03/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ´		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245454	B. WING	i			C 13/2022
NAME OF	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
SANDST	ONE HEALTH CARE	CENTER			09 COURT AVENUE SOUTH SANDSTONE, MN 55072		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	Continued From pa	ige 11	F	745			
	Threats, revised 12 any threats of suicid charge, who would situation and notify physician. The poli directed all nursing involved in the resid the resident's suicid immediately report behavior. The facilit the resident's mood	nd procedure for Suicide 2/07, directed staff to report de immediately assess the the DON, and the resident's icy and procedure further personnel and other staff dent's care, to be informed of de threat and instructed to any change in the resident's ty policy directed monitoring of d and behavior until the mined a risk of suicide was					

Facility ID: 00452

If continuation sheet Page 12 of 12



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 24, 2022

Administrator Sandstone Health Care Center 109 Court Avenue South Sandstone, MN 55072

Re: State Nursing Home Licensing Orders Event ID: 4EGT11

Dear Administrator:

The above facility was surveyed on January 12, 2022 through January 13, 2022 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

Sandstone Health Care Center January 24, 2022 Page 2 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:

Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900 Email: <u>susan.frericks@state.mn.us</u> Mobile: (218) 368-4467

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health 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

Minnesc	ta Department of He	alth				AT TROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		00452	B. WING		01/1	C 1 3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE S NE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure. Ple plan of correction y	TS: 13/22, a complaint survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 02/02/22

Electronically Signed

STATE FORM

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If continuation sheet 1 of 14

ANDSTONE (X4) ID PREFIX TAG 2 000 Co Th SL H5 iss AN Th SL H5 we	(EACH DEFICIENCY REGULATORY OR L ontinued From pa he following comp UBSTANTIATED: 5454020C (MN79 sued at 1495, and ND he following comp UBSTANTIATED: 5454021C (MN76	CENTER 109 COU SANDSTO ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 1 olaints were found to be 9279), with a licensing order d	B. WING DRESS, CITY, S RT AVENUE S DNE, MN 550 PREFIX TAG 2 000		ON LD BE	(X5) COMPLET DATE
ANDSTONE (X4) ID PREFIX TAG 2 000 Co Th SL H5 iss AN Th SL H5 we	IE HEALTH CARE SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From pa he following comp UBSTANTIATED: 5454020C (MN79 sued at 1495, and ND he following comp UBSTANTIATED: 5454021C (MN76	CENTER 109 COU SANDSTO ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 1 olaints were found to be 9279), with a licensing order d	RT AVENUE S ONE, MN 550 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLET
(X4) ID PREFIX TAG 2 000 Co Th SU H5 iss AN Th SU H5 we	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From pa be following comp UBSTANTIATED: 5454020C (MN79 sued at 1495, and ND he following comp UBSTANTIATED: 5454021C (MN76	CENTER SANDSTONT TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 1 plaints were found to be 9279), with a licensing order	DNE, MN 550 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLET
PREFIX TAG 2 000 Co Th SL H5 iss AN Th SL H5 we	(EACH DEFICIENCY REGULATORY OR L ontinued From pa he following comp UBSTANTIATED: 5454020C (MN79 sued at 1495, and ND he following comp UBSTANTIATED: 5454021C (MN76	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 1 plaints were found to be 9279), with a licensing order	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLE
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iss AN Th SL H5 we	sued at 1495, and ND he following comp UBSTANTIATED: 5454021C (MN76	d í				
Th SU H5 we	he following comp UBSTANTIATED: 5454021C (MN76	plaints were found to be				
SL H5 we	UBSTANTIATED: 5454021C (MN76	plaints were found to be				
	ere issued due to rior to the survey.	H5454019C (MN79872) and 6155), but NO licensing orders actions taken by the facility				
do Or ha sta tag "ID co of Co col vio "TH the Co Yo rec the Inf <h< td=""><td>becumenting the Si riders using Feder ave been assigned atutes/rules for N ing number appear D Prefix Tag." The Deficiencies is listed f Deficiencies col omply" portion of Dumn also include olation of the state This Rule is not more surveyor 's find lethod of Correction orrection. The surveyor 's find lethod of State lice accept of State lice the Minnesota Dep formational Bullet https://www.health</td><td>bartment of Health is tate Licensing Correction ral software. Tag numbers d to Minnesota state ursing Homes. The assigned is in the far-left column entitled e state statute/rule out of d in the "Summary Statement lumn and replaces the "To the correction order. This es the findings which are in e statute after the statement, et as evidence by." Following dings are the Suggested on and Time Period for o participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at n.state.mn.us/facilities/regulati 4_1.html> The State licensing</td><td></td><td></td><td></td><td></td></h<>	becumenting the Si riders using Feder ave been assigned atutes/rules for N ing number appear D Prefix Tag." The Deficiencies is listed f Deficiencies col omply" portion of Dumn also include olation of the state This Rule is not more surveyor 's find lethod of Correction orrection. The surveyor 's find lethod of State lice accept of State lice the Minnesota Dep formational Bullet https://www.health	bartment of Health is tate Licensing Correction ral software. Tag numbers d to Minnesota state ursing Homes. The assigned is in the far-left column entitled e state statute/rule out of d in the "Summary Statement lumn and replaces the "To the correction order. This es the findings which are in e statute after the statement, et as evidence by." Following dings are the Suggested on and Time Period for o participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at n.state.mn.us/facilities/regulati 4_1.html> The State licensing				

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If continuation sheet 2 of 14

	ta Department of H	ealth (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION (X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	· · /		IPLETED
					С
		00452	B. WING	01.	/13/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
SANDST	ONE HEALTH CARE	CENTER	JRT AVENUE		
		SANDS	TONE, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From pa	age 2	2 000		
	is necessary for St enter the word "CC available for text. A electronic State lic heading completio be corrected prior the Minnesota Dep is enrolled in ePOC not required at the state form. PLEASE DISREGA FOURTH COLUM "PROVIDER'S PLA APPLIES TO FED	Although no plan of correction ate Statutes/Rules, please DRRECTED" in the box You must then indicate in the ensure process, under the n date, the date your orders wit to electronically submitting to partment of Health. The facility C and therefore a signature is bottom of the first page of ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.	11		
21495	MN Rule 4658.100 Providing Social S	5 Subp. 5 Social Services; ervices	21495		2/11/22
	services must be p identified social se according to the co assessment and c	g social services. Social provided on the basis of rvice needs of each resident, omprehensive resident omprehensive plan of care 4658.0400 and 4658.0405.			
	by: Based on observative review, the facility related social servative include the establist care plan and infort verbalizations of servative servative care plan and servative verbalizations of servative se	tion, interview and document failed to ensure medically ices and care was provided to shment of a comprehensive ming the provider of uicidal ideation and wishes for 2 residents (R3) reviewed for ns.		R3 verbally expressed suicidal thoughts to staff. Despite implementation of immediate safety actions, care facility stat failed to complete appropriate care planning and notifications to provider and responsible parties. All residents with suicidal ideation have the potential to be affected by a deficient practice in this	

PRINTED: 02/03/2022 FORM APPROVED

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	LETED
		00452 B. WING _				, 3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE ONE, MN 55			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
21495	Continued From pa	ige 3	21495			
	Findings include: R3's Admission Record printed 1/13/22, indicated			area. All suicidal ideation stat findings to be complete by Do threats policy reviewed and re needed. DON or designee wi	ON. Suicide evised as	
	system related to a bipolar disorder.	luded degeneration of nervous lcohol, anxiety disorder, and		random audits of documenta plans to ensure appropriate r and interventions are in place occur 2x/week for 1 month, 1	otifications e. Audits to	
	12/6/22, indicated F no signs or sympto did not display any symptoms of depre down, depressed, of assessment period concentrating on th had no pain at the to was able to commu	himum Data Set (MDS) dated R3 was cognitively intact, had ms of delirium or psychosis, behaviors and had minimal ession, which included feeling or hopeless one day during the , and having trouble ings. R3's MDS indicated R3 time of the assessment, and unicate clearly, understood derstood by others.		month, 2x/month for 1 month thereafter. Audit result will be QAPI Committee for review a recommendations	brought to	
	was at risk for psyc restrictions related R3 had the potentia staff and other male impulse control, co- for injury if others g at risk to making ot lacked identification ideation and actiona- risks related to suic and interventions to of suicidal ideation	ated 11/24/21, indicated R3 shosocial well-being due to to COVID-19; and indicated al to be verbally aggressive to e resident related to poor gnitive issues, and was at risk et upset with him and R3 was hers fearful. R3's care plan n of R3's history of suicidal s, recent verbalizations and cidal ideation and self-harm, o address R3's verbalizations or self-harm, or behaviors that al ideation or self-harm.				
	included intervention directed staff to do when R3 got loud a	ant care guide dated 1/13/22, ons to ensure R3's safety and hourly activity checks, and and swore, to bring him to his r and talk to him at eye level,				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00452	B. WING	B. WING		13/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE S			
(X4) ID PREFIX TAG			ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
21495	Continued From pa	ige 4	21495			
	and if disoriented to place, remind him of where he is and R3's swearing could frighten the elderly ladies and men that lived in the facility. R3's care guide lacked interventions to ensure R3's safety for verbalizations of suicidal ideation and self-harm. R3's Order Review Report dated 1/13/22, directed monitoring for the following behaviors: restlessness (agitation), increase in complaints, kicking, cussing, elopement, hallucinations, psychosis, aggression and refusal of cares, and if any were noted, to document in nurses notes and progress notes every shift. R3's orders lacked monitoring for suicidal ideation or self-harm.					
		y and physical dated 11/2/21, history of post-traumatic SD).				
	R3 was seen at the (NP) on 11/26/21, 1 (documented R3 ha yelling and mean bo residents), 12/16/27 emergency departm had improved beha days), 12/21/21 (no legs, history of PTS yelling and mean bo residents), and 1/4/ for NP to see R3 re related to very disru	dical record (EMR) indicated facility by a nurse practitioner 1/30/21, 12/7/21, 12/14/21 ad displayed very disruptive, ehaviors toward staff and othe 1 (noted R3 had visited the nent for pain in his legs, and vior in the previous couple of oted pain and numbness to 6D, R3 had very disruptive, ehaviors to staff and other /22 (noted nursing's request garding mood and behaviors uptive, yelling and mean	r			
	behaviors to staff a dose of an antianxi night). R3's NP vis mood and behavior changes. R3's NP	nd other residents, requiring a ety medication the previous it notes addressed pain and concerns with medication visit notes lacked indication ed of R3's verbalizations of				

If continuation sheet 5 of 14

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED C
		00452	B. WING			13/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE S DNE, MN 550			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21495	Continued From pa	ge 5	21495			
	suicidal ideation and self-harm, and did not address R3's safety in regards to suicidal ideation or self-harm. A review of R3's progress notes from 11/26/21 to 1/13/22, indicated R3 made the following verbalizations regarding suicidal ideation or self-harm:					
	indicated R3 had be attempted to open to slammed it around, and became louder attempted. R3 was and one-to-one atte concern about his f "I might as well be Tylenol for leg pain, any indication of wh initiated to ensure F verbalization of self an RN, DON, socia R3's progress notes regarding any follow self-harm. R3's pro	34 p.m. R3's progress note een very agitated that morning, the medication cart and was continuously swearing, when redirection was removed from the situation ention provided. R3 expressed amily being dead and stated, dead." R3 was administered . R3's progress notes lacked nether interventions were R3's safety, whether R3's -harm was communicated to I services, or provider/NP. s lacked documentation v-up to R3's verbalizations of ogress notes lacked evidence I services were provided to onal distress.				
	into the dining room wanting to harm hir been bothering me, it was amputated. a log and a knife ar been given Tylenol on the phone about progress notes lack	32 a.m. R3 was up and going n, and was heard to verbalize nself and stated, "My leg has I have a lot of pain and I wish will amputate it myself, I need I will cut it off." Resident had earlier. R3 was heard talking amputating his leg. R3's and any indication of whether initiated to ensure R3's safety,				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00452	B. WING		01/13/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE S			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	THE APPROPRIATE D/	
21495	Continued From pa	ige 6	21495			
	communicated to an RN, DON, social services, or provider/NP. R3's progress notes lacked documentation regarding any follow-up to R3's verbalizations of self-harm. R3's progress notes lacked evidence of any psychosocial services were provided to address R3's emotional distress. -On 12/22/21, at 3:50 a.m. R3 stated "I wish I					
	could put a bullet to notes lacked any in interventions were if whether R3's suicio to an RN, DON, soo R3's progress notes regarding any follow suicidal ideation. evidence of any psy	o my brain." R3's progress				
	going to lose his ho and had some lega stated, "I would rath R3's progress note practical nurse (LPI and informed R3 sh him. R3 stated he v to him and would lik down and listen to h progress notes lack interventions were i whether R3's suicid	46 a.m. R3 was upset he was buse and his family was dead, il problems to deal with, and her take a bullet to the head." indicated the licensed N) consoled and calmed R3 he was there all day to listen to would like a chaplain to listen ke someone who could sit him to help lift his spirits. R3's ked any indication of whether initiated to ensure R3's safety, dal ideation was communicated cial services, or provider/NP.				
	R3's progress note regarding any follow suicidal ideation oth 12/24/21, as a late indicated social ser	cial services, or provider/NP. s lacked documentation w-up to R3's verbalizations of ner than documentation on entry for 12/22/21 , that vices placed a call to another therapy. R3's progress notes				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00452	B. WING		01/13/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21495	Continued From pa	ge 7	21495			
		any psychosocial services or vere provided to address R3's				
	1/13/22, further reve episodes of verbal of swearing/vulgar lan verbal threatening of progress notes lack psychosocial servic R3's emotional dist behaviors, other that as a late entry for 1	bgress notes dated 11/26/21 to ealed R3 had 9 documented outbursts with the use of guage and 3 episodes with of other residents. R3's ked evidence of any ses were provided to address ress and threatening an documentation on 12/24/21 2/22/21, that indicated social all to another facility for				
	in pain due to neuro this day. R3 stated pain and would rath very agitated, his fa stuck in this place, lucky ones." R3 de confrontations with along fine with staff his voice at others of room. R3 stated here	p.m. R3 stated he was always opathy, but it was worse on he did not get anything for her be dead. R3 stated he was unily had died, and he was then stated, "they are the nied that he had any other residents, stated he got f, and stated he did not raise or swear when outside his e has attempted suicide in the n to commit suicide at the time	5			
	(RD), stated she ha services tasks, and talked about his fee stated they were try would be more app him with psychologi director of nursing (p.m. rehabilitation director ad been helping out with social stated R3 had more recently elings and his past. The RD ving to find another facility that ropriate for R3 and would help ical services and stated the (DON) had been working with been trying to find a place for				

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Minneso	ta Department of He	ealth			FORM APPROVI	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		BERTH TO THOMBEN.	A. BUILDING:	······		
		00452	B. WING			C 13/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	ONE HEALTH CARE	CENTER 109 COU	RT AVENUE S	OUTH		
DANDST	ONE REALTH CARE	SANDST	ONE, MN 550	72		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21495	Continued From pa	age 8	21495			
	others and he was place. The RD state R3, keep him away have moved him to bathroom. The RD down, and his outb RD stated R3 had a with other residents was coming to help needed to "stream plan. On 1/12/22, at 3:28 were currently tryin appropriate mental scheduled a therap DON verified R3 ha like to shoot himse that out. The DON expresses suicidal would ensure they don't have anything and make time for his guardian to call did not need to do safety checks and on a case-by-case was new, so they w DON stated R3 had which to commit su a lot of one-to-one frequently, and his DON stated R3 had distant past when h	d R3's behaviors impacted unpredictable and all over the ed they would try to re-direct y from others when upset, and o a private room with a private stated R3 usually would calm ursts had been decreasing. a couple of verbal altercations s. RD stated the ombudsman o with R3 and stated they ine" as a team to develop a B p.m. the DON stated they g to get R3 into a more health facility and had by appointment for R3. The ad said things like he would lf, but had no means to follow stated when a resident ideation or self-harm, they were safe, make sure they g to follow through with suicide, them. For R3, it helped to call m down. The DON stated they safety checks on him, as he d about, and the frequency of other interventions would be situation. The DON stated R3 were getting to know him. The d not expressed a plan by uicide. The DON stated R3 got interactions, saw the provider pain was addressed. The d attempted suicide in the he had a lot of trauma.				
	epartment of Health					
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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00452	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/13/2022	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE		
	ONE HEALTH CARE	CENTER 109 COU	IRT AVENUE S	OUTH		
			ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21495	Continued From pa	ge 9	21495			
	On 1/13/22, at 10:35 a.m. the DON verified R3's suicidal ideation and self-harm, had not yet been care planned, DON stated they should monitor R3 every 15-30 minutes when he wass upset or expressing suicidal ideation or self-harm. The DON stated she has heard staff asking him questions regarding how he was following incidents.					
	(NA)-A, stated whe he wanted to cut his not heard that R3 h dead. NA-A stated him to his room bed	7 a.m. nursing assistant n R3 was upset and in pain, s leg off. NA-A stated she had ad said he would rather be when R3 was upset, they took cause he would scare other cked on him and left the door				
	heard R3 make cor wishing he were de take R3 to his room	9 a.m. NA-B stated she had nments regarding self-harm o ad. NA-B stated she would n, talked to him, tried to lation, and they check on R3 sure he is safe.	r			
	(RN)-A stated he ha rather be dead. RN R3 doesn't have a p around him to hurt objects. RN-A state put on safety check	8 a.m. registered nurse ad heard R3 say he would -A stated then he makes sure olan and doesn't have anything himself with, such as sharp ed he would then talk to R3, as, starting with one-to-ones, tes, then taper frequency of	9			
	been very upset wit nurses had said he	2 a.m. R3's NP stated R3 had th his pain. The NP stated the had wanted a gun but denied her incidents involving suicidal				

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	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00452	B. WING	B. WING		13/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	RT AVENUE S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
21495	R3's past suicidal a doing what they nee On 1/13/22, at 11:3 (LPN)-A, stated she wished he were dea upset with his famil she was made awa expressing the wish treatment administr him every shift. LPN threatening or in an remove him from th resident's safety. On 1/13/22, at 1:18 staff receive PTSD remember if they ha ideation. The admin been made aware of verbalizations of se 1/12/22. The admin documentation rega follow up following hi ideation, or that psy provided. The admin ideation and though been care-planned, been updated with	ge 10 ated she was not aware of ttempt, but felt the facility was ed to do to ensure his safety. 8 a.m. licensed practical nurse e had not known R3 to say he ad, but had behaviors and was y being dead. LPN-A stated if re of an episode of him n to die, she would put it on the ration record (TAR) to monitor N-A stated if he were altercation, she would he situation and ensure each p.m. the administrator stated training online, but did not ave had training on suicidal histrator verified she had not of R3's suicidal ideation or If-harm until the afternoon of histrator verified there was no arding notification of the NP, R3's incidents of suicidal vchosocial services were nistrator verified R3's suicidal hts of self-harm should have and the provider should have each occurrence, and we needed to be provided.				
	actual social service one, and had been in Moose Lake. The and certified occup assisting with social	urther stated they did not have es staff, but were trying to get consulting with a psychologist e administrator stated the RD ational therapist aid, were I services, but had been sperwork aspects of social				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/13/2022	
		00452	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SANDST	ONE HEALTH CARE	CENTER	ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21495	Continued From pa	age 11	21495			
	a link with another staff who have help MDS and paperwood families and reside frequently. The RD for a resident as a team, so all care an The RD stated they psychological servi On 1/13/22, at 2:27 provider should be	′ p.m. DON verified R3's notified of statements deation or verbalization				
	dated 5/17, identifier responsibilities, inc -communicating to service information -assisting the resid facility and maintain -developing social s follow-up progress -acting as a resider -providing counselin needed,	staff, pertinent resident social ent with adjustment to the ning periodic resident contacts services plans of care and notes,	,			
	Resident's Conditic directed the nurse physician with a sig resident's physical, The facility policy a Assessment, Interv	nd procedure for Change in a on or Status, effective 10/21, to notify the resident's gnificant change in the emotional or mental condition nd procedure for Behavioral vention and Monitoring revised sing staff to "identify,				

Minnesota Department of Health								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 01/13/2022			
		00452						
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE				
SANDST	ONE HEALTH CARE	CENTER 109 COUR	RT AVENUE S	SOUTH				
SANDST	ONE HEALTH CARE	SANDSTO	ONE, MN 550	072				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE			
21495	Continued From page 12		21495					
	specific details regarding changes in an individual's mental status, behavior, and cognition " The facility policy and procedure further directed the interdisciplinary team (IDT) to horoughly evaluate new or changing behavioral symptoms, identify underlying causes, and address potential contributing factors. In addition, he facility policy directed the IDT to, "evaluate behavioral symptoms in residents to determine he degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be mplemented immediately if necessary to protect he resident and others from harm." The IDT vould monitor the resident's progress with mpaired behavior until stable; and document any mprovements or worsening in behavior, mood, and function.							
	Threats, revised 12 any threats of suicid charge, who would situation and notify physician. The poli directed all nursing involved in the resident's suicid immediately report behavior. The facilit the resident's mood physician has deter not present SUGGESTED MET	hd procedure for Suicide /07, directed staff to report de immediately to the nurse in immediately assess the the DON, and the resident's cy and procedure further personnel and other staff dent's care, to be informed of de threat and instructed to any change in the resident's ty policy directed monitoring of d and behavior until the mined a risk of suicide was						
Norman 1	(DON), administrate and/or revise policie	designee, director of nursing or or designee could review es and procedures to ensure						
TATE FOR	epartment of Health M		6899 4	EGT11	If continuation sheet 13 of 14			

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER: 00452			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		B. WING			01/13/2022	
AME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ANDST	ONE HEALTH CARE	CENTER	IRT AVENUE S ONE, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21495	Continued From pa	age 13	21495			
		sychosocial services for erns including notificaiton to planning.				
	appropriate staff or	nee could educate the n the policies/procedures.				
	system to ensure o	nee could develop a monitoring ongoing compliance.]			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				