DEPARTMENT OF HEALTH

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

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: susan.frericks@state.mn.us
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: 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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HEALTH CARE CENTER	**109 COURT AVENUE SOUTH SANDSTONE, MN 55072**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/12/22, and 1/13/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5454020C (MN79279), with a deficiency cited at F745, and AND The following complaints were found to be SUBSTANTIATED: H5454019C (MN79872) and H5454021C (MN76155), but NO deficiencies were cited due to actions taken by the facility prior to the survey. 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 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or	F 745		2/11/22

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

Electronically 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.

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F 745	Continued From page 1 maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medically related social services and care was provided to include the establishment of a comprehensive care plan and informing the provider of verbalizations of suicidal ideation and wishes for self-harm, for 1 of 2 residents (R3) reviewed for behavioral concerns. Findings include: R3's Admission Record printed 1/13/22, indicated R3's diagnoses included degeneration of nervous system related to alcohol, anxiety disorder, and bipolar disorder. R3's admission Minimum Data Set (MDS) dated 12/6/22, indicated R3 was cognitively intact, had no signs or symptoms of delirium or psychosis, did not display any behaviors and had minimal symptoms of depression, which included feeling down, depressed, or hopeless one day during the assessment period, and having trouble concentrating on things. R3's MDS indicated R3 had no pain at the time of the assessment, and was able to communicate clearly, understood others, and was understood by others. R3's care plan initiated 11/24/21, indicated R3 was at risk for psychosocial well-being due to restrictions related to COVID-19; and indicated R3 had the potential to be verbally aggressive to staff and other male resident related to poor impulse control, cognitive issues, and was at risk for injury if others get upset with him and R3 was	F 745	R3 verbally expressed suicidal thoughts to staff. Despite implementation of immediate safety actions, care facility staff 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 area. No additional residents identified at risk at this time. Suicide threats policy reviewed and revised as needed. Education provided to all nursing staff on suicidal ideation policy and correct follow up procedures. DON or designee to complete random audits of documentation and care plans to ensure appropriate notifications and interventions are in place as follows: 3x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Audit result will be brought to QAPI Committee for review and further recommendations	

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at risk to making others fearful. R3's care plan lacked identification of R3's history of suicidal ideation and actions, recent verbalizations and risks related to suicidal ideation and self-harm, and interventions to address R3's verbalizations of suicidal ideation or self-harm, or behaviors that may indicate suicidal ideation or self-harm.

R3's nursing assistant care guide dated 1/13/22, included interventions to ensure R3's safety and directed staff to do hourly activity checks, and when R3 got loud and swore, to bring him to his room, shut the door and talk to him at eye level, 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.

R3's hospital history and physical dated 11/2/21, indicated R3 had a history of post-traumatic stress disorder (PTSD).

R3's electronic medical record (EMR) indicated R3 was seen at the facility by a nurse practitioner (NP) on 11/26/21, 11/30/21, 12/7/21, 12/14/21 (documented R3 had displayed very disruptive, yelling and mean behaviors toward staff and other residents), 12/16/21 (noted R3 had visited the

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F 745	Continued From page 3	F 745		

emergency department for pain in his legs, and had improved behavior in the previous couple of days), 12/21/21 (noted pain and numbness to legs, history of PTSD, R3 had very disruptive, yelling and mean behaviors to staff and other residents), and 1/4/22 (noted nursing's request for NP to see R3 regarding mood and behaviors related to very disruptive, yelling and mean behaviors to staff and other residents, requiring a dose of an antianxiety medication the previous night). R3's NP visit notes addressed pain and mood and behavior concerns with medication changes. R3's NP visit notes lacked indication she had been notified of R3's verbalizations of 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:

-On 12/13/21, at 1:34 p.m. R3's progress note indicated R3 had been very agitated that morning, attempted to open the medication cart and slammed it around, was continuously swearing, and became louder when redirection was attempted. R3 was removed from the situation and one-to-one attention provided. R3 expressed concern about his family being dead and stated, "I might as well be dead." R3 was administered Tylenol for leg pain. R3's progress notes lacked any indication of whether interventions were initiated to ensure R3's safety, whether R3's verbalization of self-harm was 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

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self-harm. R3's progress notes lacked evidence of any psychosocial services were provided to address R3's emotional distress.

-On 12/17/21, at 2:32 a.m. R3 was up and going into the dining room, and was heard to verbalize wanting to harm himself and stated, "My leg has been bothering me, I have a lot of pain and I wish it was amputated. I will amputate it myself, I need a log and a knife and I will cut it off." Resident had been given Tylenol earlier. R3 was heard talking on the phone about amputating his leg. R3's progress notes lacked any indication of whether interventions were initiated to ensure R3's safety, whether R3's verbalization of self-harm was 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 my brain." R3's progress notes lacked any indication of whether interventions were initiated to ensure R3's safety, whether R3's suicidal ideation was 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 suicidal ideation. . R3's progress notes lacked evidence of any psychosocial services were provided to address R3's emotional distress.

-On 12/23/21, at 6:46 a.m. R3 was upset he was going to lose his house and his family was dead, and had some legal problems to deal with, and stated, "I would rather take a bullet to the head."

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R3's progress note indicated the licensed practical nurse (LPN) consoled and calmed R3 and informed R3 she was there all day to listen to him. R3 stated he would like a chaplain to listen to him and would like someone who could sit down and listen to him to help lift his spirits. R3's progress notes lacked any indication of whether interventions were initiated to ensure R3's safety, whether R3's suicidal ideation was 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 suicidal ideation other than documentation on 12/24/21, as a late entry for 12/22/21 , that indicated social services placed a call to another facility for inpatient therapy. R3's progress notes lacked evidence of any psychosocial services or chaplain services were provided to address R3's emotional distress.

A review of R3's progress notes dated 11/26/21 to 1/13/22, further revealed R3 had 9 documented episodes of verbal outbursts with the use of swearing/vulgar language and 3 episodes with verbal threatening of other residents. R3's progress notes lacked evidence of any psychosocial services were provided to address R3's emotional distress and threatening behaviors, other than documentation on 12/24/21, as a late entry for 12/22/21, that indicated social services placed a call to another facility for inpatient therapy.

On 1/12/22, at 2:41 p.m. R3 stated he was always in pain due to neuropathy, but it was worse on this day. R3 stated he did not get anything for pain and would rather be dead. R3 stated he was very agitated, his family had died, and he was stuck in this place, then stated, "they are the

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lucky ones." R3 denied that he had any confrontations with other residents, stated he got along fine with staff, and stated he did not raise his voice at others or swear when outside his room. R3 stated he has attempted suicide in the past but had no plan to commit suicide at the time of the interview.

On 1/12/22, at 3:02 p.m. rehabilitation director (RD), stated she had been helping out with social services tasks, and stated R3 had more recently talked about his feelings and his past. The RD stated they were trying to find another facility that would be more appropriate for R3 and would help him with psychological services and stated the director of nursing (DON) had been working with him more and had been trying to find a place for him. The RD stated R3's behaviors impacted others and he was unpredictable and all over the place. The RD stated they would try to re-direct R3, keep him away from others when upset, and have moved him to a private room with a private bathroom. The RD stated R3 usually would calm down, and his outbursts had been decreasing. RD stated R3 had a couple of verbal altercations with other residents. RD stated the ombudsman was coming to help with R3 and stated they needed to "streamline" as a team to develop a plan.

On 1/12/22, at 3:28 p.m. the DON stated they were currently trying to get R3 into a more appropriate mental health facility and had scheduled a therapy appointment for R3. The DON verified R3 had said things like he would like to shoot himself, but had no means to follow that out. The DON stated when a resident expresses suicidal ideation or self-harm, they would ensure they were safe, make sure they

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don't have anything to follow through with suicide, and make time for them. For R3, it helped to call his guardian to calm down. The DON stated they did not need to do safety checks on him, as he was always out and about, and the frequency of safety checks and other interventions would be on a case-by-case situation. The DON stated R3 was new, so they were getting to know him. The DON stated R3 had not expressed a plan by which to commit suicide. The DON stated R3 got a lot of one-to-one interactions, saw the provider frequently, and his pain was addressed. The DON stated R3 had attempted suicide in the distant past when he had a lot of trauma.

On 1/12/22, at 4:45 p.m. the DON verified R3's suicidal ideation had not been care planned and it should have been.

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.

On 1/13/22, at 10:47 a.m. nursing assistant (NA)-A, stated when R3 was upset and in pain, he wanted to cut his leg off. NA-A stated she had not heard that R3 had said he would rather be dead. NA-A stated when R3 was upset, they took him to his room because he would scare other residents, they checked on him and left the door open.

On 1/13/22, at 11:19 a.m. NA-B stated she had heard R3 make comments regarding self-harm or

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wishing he were dead. NA-B stated she would take R3 to his room, talked to him, tried to de-escalate the situation, and they check on R3 frequently to make sure he is safe.

On 1/13/22, at 11:28 a.m. registered nurse (RN)-A stated he had heard R3 say he would rather be dead. RN-A stated then he makes sure R3 doesn't have a plan and doesn't have anything around him to hurt himself with, such as sharp objects. RN-A stated he would then talk to R3, put on safety checks, starting with one-to-ones, then every 15 minutes, then taper frequency of checks.

On 1/13/22, at 11:32 a.m. R3's NP stated R3 had been very upset with his pain. The NP stated the nurses had said he had wanted a gun but denied being notified of other incidents involving suicidal ideation. The NP stated she was not aware of R3's past suicidal attempt, but felt the facility was doing what they need to do to ensure his safety.

On 1/13/22, at 11:38 a.m. licensed practical nurse (LPN)-A, stated she had not known R3 to say he wished he were dead, but had behaviors and was upset with his family being dead. LPN-A stated if she was made aware of an episode of him expressing the wish to die, she would put it on the treatment administration record (TAR) to monitor him every shift. LPN-A stated if he were threatening or in an altercation, she would remove him from the situation and ensure each resident's safety.

On 1/13/22, at 1:18 p.m. the administrator stated staff receive PTSD training online, but did not remember if they have had training on suicidal ideation. The administrator verified she had not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 9	F 745		

been made aware of R3's suicidal ideation or verbalizations of self-harm until the afternoon of 1/12/22. The administrator verified there was no documentation regarding notification of the NP, follow up following R3's incidents of suicidal ideation, or that psychosocial services were provided. The administrator verified R3's suicidal ideation and thoughts of self-harm should have been care-planned, and the provider should have been updated with each occurrence, and psychosocial services needed to be provided. The administrator further stated they did not have actual social services staff, but were trying to get one, and had been consulting with a psychologist in Moose Lake. The administrator stated the RD and certified occupational therapist aid, were assisting with social services, but had been mostly doing the paperwork aspects of social services.

On 1/13/22, at 2:42 p.m. the RD stated they have a link with another clinic with a social worker and staff who have helped her with training on the MDS and paperwork. The RD stated she knew families and residents well, and worked with them frequently. The RD stated they set up resources for a resident as a team and do everything as a team, so all care areas or needs are covered. The RD stated they have been trying to get psychological services in house.

On 1/13/22, at 2:27 p.m. DON verified R3's provider should be notified of statements regarding suicidal ideation or verbalization regarding self-harm.

The facility job description for a social worker dated 5/17, identified essential duties and responsibilities, including:

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-communicating to staff, pertinent resident social service information,
-assisting the resident with adjustment to the facility and maintaining periodic resident contacts,
-developing social services plans of care and follow-up progress notes,
-acting as a resident advocate,
-providing counseling services to resident when needed,
-provide referral to appropriate resources.

The facility policy and procedure for Change in a Resident's Condition or Status, effective 10/21, directed the nurse to notify the resident's physician with a significant change in the resident's physical, emotional or mental condition.

The facility policy and procedure for Behavioral Assessment, Intervention and Monitoring revised 12/16, directed nursing staff to "identify, document, and inform the physician about 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 thoroughly evaluate new or changing behavioral symptoms, identify underlying causes, and address potential contributing factors. In addition, the facility policy directed the IDT to, "evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm." The IDT would monitor the resident's progress with impaired behavior until stable; and document any improvements or worsening in behavior, mood, and function.

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F 745	Continued From page 11 The facility policy and procedure for Suicide Threats, revised 12/07, directed staff to report any threats of suicide immediately to the nurse in charge, who would immediately assess the situation and notify the DON, and the resident's physician. The policy and procedure further directed all nursing personnel and other staff involved in the resident's care, to be informed of the resident's suicide threat and instructed to immediately report any change in the resident's behavior. The facility policy directed monitoring of the resident's mood and behavior until the physician has determined a risk of suicide was not present.	F 745		

DEPARTMENT OF HEALTH

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 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:

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: susan.frericks@state.mn.us
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

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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 1/12/22, and 1/13/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5454020C (MN79279), with a licensing order issued at 1495, and AND The following complaints were found to be SUBSTANTIATED: H5454019C (MN79872) and H5454021C (MN76155), but NO licensing orders were issued due to actions taken by the facility prior to the survey. 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 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	2 000		

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2 000	Continued From page 2 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 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		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medically related social services and care was provided to include the establishment of a comprehensive care plan and informing the provider of verbalizations of suicidal ideation and wishes for self-harm, for 1 of 2 residents (R3) reviewed for behavioral concerns.	21495	R3 verbally expressed suicidal thoughts to staff. Despite implementation of immediate safety actions, care facility staff 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	2/11/22

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21495	Continued From page 3 Findings include: R3's Admission Record printed 1/13/22, indicated R3's diagnoses included degeneration of nervous system related to alcohol, anxiety disorder, and bipolar disorder. R3's admission Minimum Data Set (MDS) dated 12/6/22, indicated R3 was cognitively intact, had no signs or symptoms of delirium or psychosis, did not display any behaviors and had minimal symptoms of depression, which included feeling down, depressed, or hopeless one day during the assessment period, and having trouble concentrating on things. R3's MDS indicated R3 had no pain at the time of the assessment, and was able to communicate clearly, understood others, and was understood by others. R3's care plan initiated 11/24/21, indicated R3 was at risk for psychosocial well-being due to restrictions related to COVID-19; and indicated R3 had the potential to be verbally aggressive to staff and other male resident related to poor impulse control, cognitive issues, and was at risk for injury if others get upset with him and R3 was at risk to making others fearful. R3's care plan lacked identification of R3's history of suicidal ideation and actions, recent verbalizations and risks related to suicidal ideation and self-harm, and interventions to address R3's verbalizations of suicidal ideation or self-harm, or behaviors that may indicate suicidal ideation or self-harm. R3's nursing assistant care guide dated 1/13/22, included interventions to ensure R3's safety and directed staff to do hourly activity checks, and when R3 got loud and swore, to bring him to his room, shut the door and talk to him at eye level,	21495	area. All suicidal ideation staff training on findings to be complete by DON. Suicide threats policy reviewed and revised as needed. DON or designee will complete random audits of documentation and care plans to ensure appropriate notifications and interventions are in place. Audits to occur 2x/week for 1 month, 1x/week for 1 month, 2x/month for 1 month, and monthly thereafter. Audit result will be brought to QAPI Committee for review and further recommendations	

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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.

R3's hospital history and physical dated 11/2/21, indicated R3 had a history of post-traumatic stress disorder (PTSD).

R3's electronic medical record (EMR) indicated R3 was seen at the facility by a nurse practitioner (NP) on 11/26/21, 11/30/21, 12/7/21, 12/14/21 (documented R3 had displayed very disruptive, yelling and mean behaviors toward staff and other residents), 12/16/21 (noted R3 had visited the emergency department for pain in his legs, and had improved behavior in the previous couple of days), 12/21/21 (noted pain and numbness to legs, history of PTSD, R3 had very disruptive, yelling and mean behaviors to staff and other residents), and 1/4/22 (noted nursing's request for NP to see R3 regarding mood and behaviors related to very disruptive, yelling and mean behaviors to staff and other residents, requiring a dose of an antianxiety medication the previous night). R3's NP visit notes addressed pain and mood and behavior concerns with medication changes. R3's NP visit notes lacked indication she had been notified of R3's verbalizations of

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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:

-On 12/13/21, at 1:34 p.m. R3's progress note indicated R3 had been very agitated that morning, attempted to open the medication cart and slammed it around, was continuously swearing, and became louder when redirection was attempted. R3 was removed from the situation and one-to-one attention provided. R3 expressed concern about his family being dead and stated, "I might as well be dead." R3 was administered Tylenol for leg pain. R3's progress notes lacked any indication of whether interventions were initiated to ensure R3's safety, whether R3's verbalization of self-harm was 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 12/17/21, at 2:32 a.m. R3 was up and going into the dining room, and was heard to verbalize wanting to harm himself and stated, "My leg has been bothering me, I have a lot of pain and I wish it was amputated. I will amputate it myself, I need a log and a knife and I will cut it off." Resident had been given Tylenol earlier. R3 was heard talking on the phone about amputating his leg. R3's progress notes lacked any indication of whether interventions were initiated to ensure R3's safety, whether R3's verbalization of self-harm was

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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 my brain." R3's progress notes lacked any indication of whether interventions were initiated to ensure R3's safety, whether R3's suicidal ideation was 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 suicidal ideation. . R3's progress notes lacked evidence of any psychosocial services were provided to address R3's emotional distress.

-On 12/23/21, at 6:46 a.m. R3 was upset he was going to lose his house and his family was dead, and had some legal problems to deal with, and stated, "I would rather take a bullet to the head." R3's progress note indicated the licensed practical nurse (LPN) consoled and calmed R3 and informed R3 she was there all day to listen to him. R3 stated he would like a chaplain to listen to him and would like someone who could sit down and listen to him to help lift his spirits. R3's progress notes lacked any indication of whether interventions were initiated to ensure R3's safety, whether R3's suicidal ideation was 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 suicidal ideation other than documentation on 12/24/21, as a late entry for 12/22/21 , that indicated social services placed a call to another facility for inpatient therapy. R3's progress notes

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lacked evidence of any psychosocial services or chaplain services were provided to address R3's emotional distress.

A review of R3's progress notes dated 11/26/21 to 1/13/22, further revealed R3 had 9 documented episodes of verbal outbursts with the use of swearing/vulgar language and 3 episodes with verbal threatening of other residents. R3's progress notes lacked evidence of any psychosocial services were provided to address R3's emotional distress and threatening behaviors, other than documentation on 12/24/21, as a late entry for 12/22/21, that indicated social services placed a call to another facility for inpatient therapy.

On 1/12/22, at 2:41 p.m. R3 stated he was always in pain due to neuropathy, but it was worse on this day. R3 stated he did not get anything for pain and would rather be dead. R3 stated he was very agitated, his family had died, and he was stuck in this place, then stated, "they are the lucky ones." R3 denied that he had any confrontations with other residents, stated he got along fine with staff, and stated he did not raise his voice at others or swear when outside his room. R3 stated he has attempted suicide in the past but had no plan to commit suicide at the time of the interview.

On 1/12/22, at 3:02 p.m. rehabilitation director (RD), stated she had been helping out with social services tasks, and stated R3 had more recently talked about his feelings and his past. The RD stated they were trying to find another facility that would be more appropriate for R3 and would help him with psychological services and stated the director of nursing (DON) had been working with him more and had been trying to find a place for

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him. The RD stated R3's behaviors impacted others and he was unpredictable and all over the place. The RD stated they would try to re-direct R3, keep him away from others when upset, and have moved him to a private room with a private bathroom. The RD stated R3 usually would calm down, and his outbursts had been decreasing. RD stated R3 had a couple of verbal altercations with other residents. RD stated the ombudsman was coming to help with R3 and stated they needed to "streamline" as a team to develop a plan.

On 1/12/22, at 3:28 p.m. the DON stated they were currently trying to get R3 into a more appropriate mental health facility and had scheduled a therapy appointment for R3. The DON verified R3 had said things like he would like to shoot himself, but had no means to follow that out. The DON stated when a resident expresses suicidal ideation or self-harm, they would ensure they were safe, make sure they don't have anything to follow through with suicide, and make time for them. For R3, it helped to call his guardian to calm down. The DON stated they did not need to do safety checks on him, as he was always out and about, and the frequency of safety checks and other interventions would be on a case-by-case situation. The DON stated R3 was new, so they were getting to know him. The DON stated R3 had not expressed a plan by which to commit suicide. The DON stated R3 got a lot of one-to-one interactions, saw the provider frequently, and his pain was addressed. The DON stated R3 had attempted suicide in the distant past when he had a lot of trauma.

On 1/12/22, at 4:45 p.m. the DON verified R3's suicidal ideation had not been care planned and it should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00452	A. BUILDING: _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE HEALTH CARE CENTER	109 COURT AVENUE SOUTH SANDSTONE, MN 55072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21495	Continued From page 9 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. On 1/13/22, at 10:47 a.m. nursing assistant (NA)-A, stated when R3 was upset and in pain, he wanted to cut his leg off. NA-A stated she had not heard that R3 had said he would rather be dead. NA-A stated when R3 was upset, they took him to his room because he would scare other residents, they checked on him and left the door open. On 1/13/22, at 11:19 a.m. NA-B stated she had heard R3 make comments regarding self-harm or wishing he were dead. NA-B stated she would take R3 to his room, talked to him, tried to de-escalate the situation, and they check on R3 frequently to make sure he is safe. On 1/13/22, at 11:28 a.m. registered nurse (RN)-A stated he had heard R3 say he would rather be dead. RN-A stated then he makes sure R3 doesn't have a plan and doesn't have anything around him to hurt himself with, such as sharp objects. RN-A stated he would then talk to R3, put on safety checks, starting with one-to-ones, then every 15 minutes, then taper frequency of checks. On 1/13/22, at 11:32 a.m. R3's NP stated R3 had been very upset with his pain. The NP stated the nurses had said he had wanted a gun but denied being notified of other incidents involving suicidal	21495		

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ideation. The NP stated she was not aware of R3's past suicidal attempt, but felt the facility was doing what they need to do to ensure his safety.

On 1/13/22, at 11:38 a.m. licensed practical nurse (LPN)-A, stated she had not known R3 to say he wished he were dead, but had behaviors and was upset with his family being dead. LPN-A stated if she was made aware of an episode of him expressing the wish to die, she would put it on the treatment administration record (TAR) to monitor him every shift. LPN-A stated if he were threatening or in an altercation, she would remove him from the situation and ensure each resident's safety.

On 1/13/22, at 1:18 p.m. the administrator stated staff receive PTSD training online, but did not remember if they have had training on suicidal ideation. The administrator verified she had not been made aware of R3's suicidal ideation or verbalizations of self-harm until the afternoon of 1/12/22. The administrator verified there was no documentation regarding notification of the NP, follow up following R3's incidents of suicidal ideation, or that psychosocial services were provided. The administrator verified R3's suicidal ideation and thoughts of self-harm should have been care-planned, and the provider should have been updated with each occurrence, and psychosocial services needed to be provided. The administrator further stated they did not have actual social services staff, but were trying to get one, and had been consulting with a psychologist in Moose Lake. The administrator stated the RD and certified occupational therapist aid, were assisting with social services, but had been mostly doing the paperwork aspects of social services.

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21495	Continued From page 11 On 1/13/22, at 2:42 p.m. the RD stated they have a link with another clinic with a social worker and staff who have helped her with training on the MDS and paperwork. The RD stated she knew families and residents well, and worked with them frequently. The RD stated they set up resources for a resident as a team and do everything as a team, so all care areas or needs are covered. The RD stated they have been trying to get psychological services in house. On 1/13/22, at 2:27 p.m. DON verified R3's provider should be notified of statements regarding suicidal ideation or verbalization regarding self-harm. The facility job description for a social worker dated 5/17, identified essential duties and responsibilities, including: -communicating to staff, pertinent resident social service information, -assisting the resident with adjustment to the facility and maintaining periodic resident contacts, -developing social services plans of care and follow-up progress notes, -acting as a resident advocate, -providing counseling services to resident when needed, -provide referral to appropriate resources. The facility policy and procedure for Change in a Resident's Condition or Status, effective 10/21, directed the nurse to notify the resident's physician with a significant change in the resident's physical, emotional or mental condition. The facility policy and procedure for Behavioral Assessment, Intervention and Monitoring revised 12/16, directed nursing staff to "identify, document, and inform the physician about	21495		

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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 thoroughly evaluate new or changing behavioral symptoms, identify underlying causes, and address potential contributing factors. In addition, the facility policy directed the IDT to, "evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm." The IDT would monitor the resident's progress with impaired behavior until stable; and document any improvements or worsening in behavior, mood, and function.

The facility policy and procedure for Suicide Threats, revised 12/07, directed staff to report any threats of suicide immediately to the nurse in charge, who would immediately assess the situation and notify the DON, and the resident's physician. The policy and procedure further directed all nursing personnel and other staff involved in the resident's care, to be informed of the resident's suicide threat and instructed to immediately report any change in the resident's behavior. The facility policy directed monitoring of the resident's mood and behavior until the physician has determined a risk of suicide was not present

SUGGESTED METHOD FOR CORRECTION:

The social services designee, director of nursing (DON), administrator or designee could review and/or revise policies and procedures to ensure

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21495	Continued From page 13 residents receive psychosocial services for mental health concerns including notificaiton to provider and care planning. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21495		