STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centracare Health System-Sauk Centre Nursing Home	425 N Elm Street Sauk Centre, MN 56378

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20794 Based on interview and document review, the facility failed to ensure resident's physician and responsible parties were notified in a timely manner for 1 of 1 resident (R1) reviewed for notification of change, who had increasing depression and had attempted to harm self. Findings include: A Vulnerable Adult Maltreatment Report dated 8/15/24, identified a report had been submitted for R1 which alleged resident's increasing depression, anxiety and attempt to strangle self with resident's nasal cannula (tubing attached to an oxygen source to deliver oxygen). These included increased comments voiced by R1 of telling family members she would rather die than stay here, and on 8/13/24 that she was going to kill herself. On 8/13/24 at 9:55 p.m., licensed practical nurse (LPN)-A, documented in R1's medical record, Resident stated she was going to kill herself and had her oxygen cannula wrapped around her neck. Staff removed the cannula around the neck. [Daughter] [family member (FM)-B], is currently visiting with her to help her sleep. Resident states she sees people outside her window as well. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 was moderately cognitively impaired, fed self after set up, but required extensive assistance for transfers, dressing, grooming and toileting. Further, the MDS documented diagnoses of chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, hypertension, cirrhosis, insulin dependent diabetes, major depression, and arthritis. R1's Care Area Assessment (CAA) for Cognitive Loss / Dementia, (from the admission MDS - dated 6/27/24), the facility documented the following: Resident does have a diagnosis of cognitive decline as well as delirium. She also has mild recurrent major depressive disorder. In regard to respiratory, she has a diagnosis of chronic respiratory failure with hypoxia, chronic interstitial lung disease and a [history] of pneumonia. Resident also has liver cirrhosis and fatty liver disease. In regards to possible incontinence she has a diagnosis of bladder cancer . R1's Preadmission Screening and Resident Review (PASARR) dated 6/18/24, indicated R1 did not have any developmental disability, mental illness, suicidal ideation nor civil confinement for mental illness. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Clinical Resident Profile from her electronic medical records (print date of 8/21/24), listed R1's primary physician's name and contact number, as well as the contact information for three family members. The family members were listed in order of who was to be contacted first. R1's electronic medical record (EMR) from the time of LPN-A's entry on 8/13/24 at 9:55 p.m., lacked what interventions and safety measures the facility staff implemented, until 8/14/24 at 8:48 a.m., when social services assessed R1 and contacted resident's primary physician and daughter. In a telephone interview on 8/20/24 at 11:35 a.m., LPN-A stated one of the nursing assistant (NA)-A came up to her and stated R1 voiced she wanted to die. LPN-A suggested to the NA-A to bring R1 out of her room to the day room and offer her coffee and a snack (the dayroom was across from the nurse station) to be more easily observed. At approximately 9:00 p.m., LPN-A stated the NA's (NA-A and NA-B) offered to get R1 ready for bed and R1 agreed. At approximately 9:30 p.m., LPN-A stated NA-A came to get her and said R1 was wrapping her nasal cannula around her neck. LPN-A entered the room noting NA-B holding R1's hands. LPN-A and NA's removed the cannula. While LPN-A was settling R1, she sent one of the NA's to call R1's daughter to see if she would come in and sit with R1 until she fell asleep. LPN-A stated family member (FAM)-B came in and sat with R1 until she fell asleep, leaving at 2:00 a.m. LPN-A verified neither she nor the NA informed family (FAM-A and FAM-B) of R1 wrapping the nasal cannula around her neck. Nor did the facility contact R1's primary physician or any on-call physicians. LPN-A stated the only conversation she had with FAM-B was FAM-B wanting the nurse to give R1 something to knock her out. LPN-A stated they did not have any orders for that type of intervention. LPN-A was asked if during that conversation, had she mentioned to FAM-B about R1's incident. LPN-A stated: no I didn't, she was kind a stand-off-ish. LPN-A stated from the time FAM-B left until morning staff came on (2:00 a.m. - 6:30 a.m.), she and the two NAs checked on R1 every 30 minutes, finding her sleeping until 6:30 a.m., when R1 requested to be toileted. During telephone interview on 8/20/24 at 11:51 a.m., the reporter (Report) stated the facility did not do enough to monitor R1's safety after finding R1 with the nasal cannula around her neck. Report stated the staff should have called the primary MD, on-call physician or brought her to the adjoining emergency room . An interview on 8/20/24 at 12:22 p.m., director of nursing (DON) stated after review of R1's EMR documentation during and after the incident, LPN-A lacked appropriate documentation to fully understand what occurred. DON verified the record lacked evidence that R1's primary physician / on call physician and family were contacted. During telephone interview on 8/20/24 at 2:05 p.m., FAM-A verified someone from the facility had called her around 9:30 p.m. on 8/13/24. However, she was only told that R1 was upset and wanted family to come in to visit. FAM-A stated she called FAM-B and requested FAM-B to go in and sit with R1. When asked if R1 would have the ability to follow through on harming herself, FAM-A only stated, R1's actions were not purposeful. An interview on 8/21/24 at 8:11 a.m., social work designee (SWD) stated she had not been informed of R1's attempt to harm self until the next morning during stand-up meeting with the interdisciplinary team. SWD performed a PHQ-9 (a depression assessment) and found R1's score greatly increased from admission over a month ago. SWD then performed a Columbia Suicide Assessment and found R1's score high. The facility then contacted R1's primary physician and FAM-A and transferred R1 to the adjoining emergency room for further assessment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 8/21/24 at 9:48 a.m., R1's primary physician (PP) verified neither he nor the on-call physician had been contacted about R1's incident of wrapping the nasal cannula around her neck until the morning of 8/14/24. PP stated he has known R1 for about [AGE] years and did not feel she was capable of mentally or physical strength to following through on the act. PP stated the facility staff should have contacted him or the on-call physician immediately for orders and further assessment. PP mentioned labs and CT scans were completed the day prior and found R1's liver function and ammonia levels were elevated. PP stated this could be root cause for the change in mental disturbance and her actions. When asked about facility staff monitoring R1 only every 30 minutes from 2:00 a.m. until 6:30 a.m., PP responded at least they did that. On 8/21/24, between 10:07 a.m. and 10:18 a.m., attempted to make contact with the two NAs (NA-A and NA-B) on the relief shift of 8/13/24, and the two NAs (NA-C and NA-D) on the night shift (scheduled from 8/13/24 until the morning of 8/14/24), receiving no return calls or messages. During an interview on 8/21/24 at 11:03 a.m., the facility administrator stated during general orientation all staff were educated in Vulnerable Adult regulations. In that education suicide was briefly discussed. Since this incident, all staff were provided copies of the facility's policy on Suicide Prevention. Furthermore, all staff have been assigned an online course in EDUCARE on Vulnerable Adult with a section on suicide prevention. Staff are to have it completed by Wednesday August 28, 2024. In review of the facility's policy, entitled: Suicide Prevention (effective date 01/2024) indicated in the following sections: A. Staff will notify Social Services of a resident making suicidal comments. If Social Services is not available, will notify the charge nurse. D. Social Services and/or the nurse will document investigation with the resident in the progress notes section of the medical record. E. If a resident is found to be actively suicidal, with the intent to harm self and meaningful plan the resident will not be left unattended. G. The resident's provider or provider [on-call] will be notified of situation, provider orders obtained as to what staff should do for resident. Orders will be followed. I. Responsible party of resident will be updated on resident's situation.