STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sacred Heart Care Center	1200 12th Street Southwest Austin, MN 55912

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a Level II Pre-admission Screening and Resident Review (PASARR) was completed for 1 of 2 resident (R3) reviewed for PASARR R3's Minimum Data Set (MDS) assessment dated , 4/23/25, indicated R3 had intact cognition, adequate hearing, clear speech, can understand others, and able to make needs known.R3 was admitted on [DATE] with diagnoses of Personality Disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems), Suicidal Ideation ((SI) thinking about or planning to harm yourself), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Generalized Anxiety Disorder (mental health condition characterized by persistent and excessive worry about a variety of events or activities), and Post-traumatic Stress Disorder (mental health condition that can develop after experiencing or witnessing a traumatic event).R'3 current medications include hydroxyzine for general anxiety disorder and imipramine for major depressive disorder.Facility document titled, Senior 'LinkAge Line dated 1/30/2023, indicated R3 had a primary diagnosis of severe major depressive disorder. Yes for R3 having a current diagnosis of a mental illness. Yes for R3 having a mental illness as the primary diagnosis for hospitalization. Yes for R3 having a mental illness that has significantly interfered with functioning. Yes for R3 needing supportive services or interventions due to a mental illness. The document indicated R3's provided information met criteria for Mental Illness (MI) and needed to be referred to lead agency for further evaluation (level 2 PASARR).During interview on 7/24/25 at 9:19 a.m., assistant director of nursing (ADON) confirmed R3's level 1 PASARR was completed on 1/30/23; indicating R3 met criteria for a level 2 PASARR. ADON confirmed R3's level 2 PASARR had not been completed.During interview on 7/24/25 at 9:29 a.m., director of nursing (DON) and regional consulting registered nurse (RC-RN) confirmed R3's admission diagnosis and R3 met the criteria for completing a level 1 PASARR. DON and RC-RN confirmed R3 had a completed level 1 PASARR dated 1/30/23. DON and RC-RN confirmed the level 1 PASARR indicated R3 should have a level 2 PASARR. DON and RC-RN confirmed the level 2 PASARR had not been completed. An undated facility policy titled Mood and Behavior Policy, the facility will complete a level 1 PASARR for all new admissions, completing a level 2 PASARR as indicated before admission to the facility.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a process was in place to maintain 4 of 4 MedCare mechanical lifts and 2 of 4 MedCare sit to stands. This practice had the potential for unsafe transfers of 11 of 11 residents (R6, R16, R19, R23, R27, R35, R38, R42 R4, R20, R33) when it was identified the equipment used was missing safety parts used to help prevent accidents and hazards and equipment was not routinely maintained per manufacturer's recommendation.Finding includes:R6, R16, R19, R23, R27, R35, R38, R42, R4, R20 and R33, care plans included nursing staff to provide 2-person assistance for transfers and mobility either with a mechanical lift or a sit to stand lift.During an observation and interview on [DATE] at 1:42 p.m., nursing assistant (NA)-B identified 2 mechanical lifts labeled 31, 32 and a sit to stand lift numbered 30 missing rubber sling stoppers on the 4-point sling support hook. NA-B indicated a few of the mechanical lifts in the facility had rubber sling stoppers in place and nursing staff are directed to use the mechanical lifts for resident transfers. NA-B acknowledged the rubber sling stopper were to prevent the slings from sliding out of the sling support bar during transfers and to prevent resident falls from the lift, if not properly secured.During an interview on [DATE] at 8:32 a.m., maintenance technician identified the facility administration informed him the rubber sling stoppers were to be ordered and placed on the mechanical lifts. Several of the lifts had received rubber sling stoppers, however, the facility was awaiting delivery of additional rubber sling stoppers to be applied to the remainder of the lifts. He was aware the nursing staff were to use the mechanical lifts and identified routine maintenance checks and cleaning was needed for all lifts on a routine basis.Further observation on [DATE] at 9:22 a.m., wing three (3) had two (2) mechanical lifts with number 26, 27, and a sit to stand numbered 28, all included serial numbers on the labels, and all missing rubber sling stoppers.During an observation on [DATE] at 9:48 a.m., NA-C and NA-Z went in to assist R27. NA-B and NA-Z applied a yellow sling sheet under R27's back. The mechanical lift number 31 was used and was noticed to be missing the rubber sling stoppers. R27 was lifted off the bed and was transferred to R27's wheelchair. Review of a Check off List for Lifts 2025, identified number 26, 27, 31, and 32, had a routine safety check completed in the month of July.Review of Check off list for Stands 2025, identified 28 and 30 had a routine safety check completed in the month of July.Prior months Check off List for January through [DATE] lacked evidence safety checks were completed on the mechanical lifts to determine if the equipment was appropriate for resident use.Interview on [DATE] at 1:03 p.m., maintenance director who had been employed for two months had no formal training of lift maintenance, upon hire. The mechanical lifts safety check was completed once after he started and was for the month of [DATE]. In addition, the facility records lacked documentation of a lift maintenance program. He identified the facility had no process in place to ensure the mechanical lift devices were checked monthly for resident use.Interview on [DATE] at 2:34 p.m., MedCare sales representative identified the facility's mechanical lift with serial number 0203LF0412 labeled #32, was manufactured in 2002 and was [AGE] years old. She identified mechanical lifts was designed to last 20 years, however, after 10 years they recommend the lift to be replaced. Although after 10 years, the mechanical lift may continue to be used, provided routine maintenance was performed to ensure the integrity of the structure and function of the lift. If, routine maintenance was not performed on a routine basis, the mechanical lift was to be pulled out of service. In addition, the company stopped providing routine maintenance checks on mechanical lifts in 2018, however, the company would need to make arrangements for an authorized dealer in the local area to provide checks upon request from the facility. Follow up interview on [DATE] at 4:32 p.m., with maintenance director identified he was not aware one of the mechanical lifts was expired and had no knowledge of how to verify when a lift was expired. He previously, sent an email to the manufacture to verify information of the lifts used at the facility and had not received a reply, however the lift remained on the unit for use. When asked about the expired mechanical lift that had not received routine safety checks, was it safe for resident use, he had no response. He acknowledged he recently created a checklist based on the MedCare Manufacturer's preventative checklist for lift maintenance and safety check. However, his checklist did not include the manufacturer's recommendation to contact a safe patient handling consultant for lifts beyond the life expectancy of 10 years. Interview on [DATE] 5:32 p.m., with LPN-B and NA-D both identified the rubber sling stoppers was not placed on all the mechanical lifts. Interview on [DATE] at 10:37 a.m., with director of nursing (DON) identified, several months prior, the facility lacked a thorough training plan for new hires that was to include components of nursing care, including use

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to comprehensively assess past trauma and implement individualized care plan interventions utilizing a trauma-informed approach for 1 of 2 residents (R3) reviewed who had post-traumatic stress disorder (PTSD) symptoms.Findings include:R3's Minimum Data Set (MDS) assessment dated [DATE] indicated R3 had intact cognition, adequate hearing, clear speech, can understand others, adequate hearing, and able to make needs known.R3 was admitted on [DATE] with diagnoses of Personality Disorder ((PD) a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems), Suicidal Ideation ((SI) thinking about or planning to harm yourself), Major Depressive Disorder ((MDD) mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Generalized Anxiety Disorder ((GAD) mental health condition characterized by persistent and excessive worry about a variety of events or activities), and Post-traumatic Stress Disorder ((PTSD) mental health condition that can develop after experiencing or witnessing a traumatic event).R'3 current medications include hydroxyzine for general anxiety disorder and imipramine for major depressive disorder.R3's care plan dated 2/7/23, identified a potential for altered mood related to PTSD, MDD, GAD, SI, and PD. R3's interventions for altered mood included opportunity to express self, contact family, contact provider, encourage activity participation, medicate as ordered, monitor side effects, monitor changes/declines in mood, and redirect/reorient/reassure as needed.R3's care plan dated 2/7/23, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization.During interview on 7/24/5 at 8:59 a.m., R3 stated the sign on her door was because she does not like loud noises; they scare her. She prefers visitors and staff knock softly so she does not get scared. R3 stated she believes this was due to her past trauma; she just doesn't like loud startling noises. R3 stated facility staff have not asked her about her past trauma, so she is unsure if they know anything.During interview on 7/24/25 at 9:14 a.m., infection preventionist (IP) who was immediately outside resident room, stated she did not believe R3 had a diagnosis of PTSD. IP stated she does not think R3 had any other mental health diagnosis.During interview on 7/24/25 at 9:16 a.m., nursing assistant (NA)-A stated, to her knowledge, the resident does not have a PTSD diagnosis. NA-A stated R3 does not have any PTSD-related triggers.During interview on 7/24/25 at 9:19 a.m., assistant director of nursing (ADON) stated resident does have a diagnosis of PTSD, anxiety, and depression. ADON confirmed R3 does not have a PTSD-specific care plan with related interventions to prevent re-traumatization. ADON confirmed R3 should have a PTSD-specific care plan.During interview on 7/24/25 at 9:29 a.m., director of nursing (DON) and regional consulting registered nurse (RC-RN) confirmed R3's admission diagnosis of PTSD. DON and RC-RN confirmed R3 does not have a PTSD-specific care plan with related interventions to prevent re-traumatization. ADON confirmed R3 should have a PTSD-specific care plan.A facility policy titled Trauma Informed Care and Culturally Competent Care dated August 2022, the facility will address the needs of trauma survivors by minimizing triggers and/or re-traumatization by developing individualized trauma-based care plans that address past trauma.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and document review, the facility failed to ensure staff were appropriately trained and educated on how to identify and report mechanical lift maintenance concerns to prevent accidents and hazards. This practice had the potential to affect 11 of 11 residents who were assessed to use the mechanical lifts and stands.Findings include:Review of July 2025 mandatory training skills fair attendance sheet identified 27 of 88 nursing staff had completed the competency checklist.During an observation and interview on 7/21/25 at 1:42 p.m., nursing assistant (NA)-B identified 2 mechanical lifts labeled 31, 32 and 30 a sit to stand lift was missing rubber sling stoppers on the 4-point sling support hook. NA-B identified only a few of the mechanical lifts in the facility had rubber sling stoppers in place and nursing staff was directed to use the mechanical lifts for resident transfers. NA-B acknowledge the rubber sling stopper was to prevent the slings from sliding out of the sling support bar during transfers and to prevent resident falls from the lift, if not properly secured.Further observation on 7/22/25 at 9:22 a.m., identified on wing 3 had 2 mechanical lifts labeled 26, 27 and 28 a sit to stand lift was missing rubber sling stoppers. During an interview on 7/22/25 at 5:30 p.m., licensed practical nurse (LPN)-A confirmed the mechanical lifts did not have rubber sling stoppers in place and verified unawareness the reason for the rubber sling stoppers. Interview on 07/22/25 at 5:34 p.m., with NA-E identified the mechanical lifts was to have rubber stoppers in place and had not seen them on all of the lifts. NA-E identified when he uses a mechanical lift with no rubber stopper in place he would double loop the strap to prevent the sling from sliding off. Interview on 07/23/2025 at 6:54 a.m., with registered nurse (RN)-A and NA-G identified the mechanical lift required 2 nursing staff to assist residents with transfers. Both RN-A and NA-G was unsure of the reason for the rubber sling stoppers. However, NA-G identified the rubber sling stoppers was not important and the lift could still be used to transfer residents.Interview on 07/23/2025 at 7:04 a.m., with RN-B was unsure of the reason for rubber sling stoppers on the mechanical lift. Interview on 7/23/25 at 10:37 a.m., with director of nursing (DON) identified the facility implemented a performance improvement project (PIP) to identify current training processes and improve onboarding practices and staff knowledge to safely provide quality care to residents. Review of April 2025 facility assessment identified the facility utilized corporate resources to train and hire employees, based on experience and competency to ensure continuity of care across all departments, when needed. The facility was to provide information and training that was consistent with standards of practice and facility management was to meet to consider standards of care to ensure nursing staff was knowledgeable to safely care for residents. Education for nursing staff was vital in providing the highest level of care to residents and was to include Client Mobility: Exercise and Ambulation, Lifting and Safe Transfers, Positioning and Range of motion and Minnesota Safe Patient Handling, upon hire. Ongoing annual training of nursing staff was to include Accident prevention and safety measures by Occupational Safety and Health Administration (OSHA). In addition, the medical director was responsible of resident care policies and procedures and was an active participant of all staff education meetings.Interview on 7/23/2025 4:40 p.m., the administrator was hired March 2025 and was unsure if the facility had reached out to the mechanical lift manufacturer to provide a mechanical service part evaluation on the lifts. She was aware the facility had a monthly checklist for routine maintenance to be completed on all lifts implemented by the maintenance director. However, she had no knowledge the facility had an older lift, not routinely checked for maintenance and was in service on the units. The facility held a mandatory skills training in July 2025 for nursing staff to be educated on the mechanical lifts, however, she identified nursing staff could return to work and continue to transfer residents with the mechanical lifts, even though the mandatory training was not completed for all employees. She acknowledged, it would be difficult for nursing staff to identify and voice maintenance concerns when they have not received appropriate training on equipment use. Review of revised July 2025 Lifting Machine, Using a Mechanical policy identified the nursing staff was to demonstrate competency to ensure safe lifting practices when using the mechanical device in the facility.Review of revised July 2025 General Orientation Policy for Staff identified nursing staff was to receive a comprehensive orientation to promote regulatory compliance and enhance resident safety. All employees, regardless of their role or classification was to participate in a structured orientation program before assuming independent responsibilities when caring for residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employees would be able to return to work after an illness, dependent upon their symptoms for 2 of 3 sampled staff (certified nursing assistant (NA)-Y and dietary aide (DA)-A). This had the potential to affect all 50 residents, staff and visitors. Findings include: Review of Employee Illness logs from May through July 2025 identified the following areas of documentation: department, employee name, job title, symptom onset, illness reported, last shift worked, resolution date, return to work, specimen source, and treatment results. However, the facility did not accurately complete the logs to ensure all necessary information was monitored or identified how staff were cleared to return to work. Review of Centers for Disease Control (CDC) article, Norovirus, located at https://www.cdc.gov/norovirus/about/index.html, identified Norovirus is a contagious virus that spreads through direct contact with another person. Symptoms develop 12 to 48 hours after being exposed to norovirus. Prevention was to wash your hands, often, clean and disinfect contaminated surfaces and stay home when sick for 2 days after symptoms stop. Symptoms improve after 1 to 3 days, however, there is no treatment to alleviate norovirus symptoms. Review of the Centers for Disease Control (CDC) article, Clinical Guidance for Group A Streptococcal Pharyngitis, located at https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html, identified Strep is spread through close contact with another person. Crowded settings can increase the risk for spreading the bacteria. Treatment with an appropriate antibiotic for 12 hours or longer limits the person's ability to transmit Strep. Persons infected should stay home from work until both conditions are met: 1) They are without fever. 2) At least 12-24 hours after starting an appropriate antibiotic. Review of June 2025, employee illness log identified DA-A was noted to have called in to work with symptoms of nausea and an upset stomach related to an unknown gastro-intestinal (GI) illness on 6/13/25. Review of DA-A timesheet identified DA-A had worked on 6/13/25 from 7:02 a.m. to 7:12 a.m., for a total of 15 minutes. The log further identified DA-A worked in the kitchen and rarely had exposure to residents. Review of June 2025, employee illness log identified NA-Y was noted to have called in to work with symptoms of sore throat on 6/20/25. Review of NA-Y timesheet identified NA-Y had worked on 6/20/25 from 8:00 a.m. to 10:45 a.m., for a total of 2.75 hours. The log identified NA-Y was found positive with strep throat. NA-Y returned to work on 6/25/25. Review of June 2025, resident infection log identified no residents with outbreak of strep or GI illnesses. Review of July 2025, employee illness log identified NA-Y was noted to have called in to work with symptoms of diarrhea on 7/07/25. Review of NA-Y timesheet identified NA-Y had worked on 7/07/25 from 4:06 p.m. to 10:51 p.m. The log further identified NA-Y was on break for one hour with symptoms of diarrhea and returned back to work the same day to finish her shift.Overall, there was no mention when DA-A and NA-Y symptoms resolved prior to returning to work. Review of July 2025, resident infection log identified no resident with GI illnesses. Interview on 7/25/25 at 08:54 a.m., with registered nurse (RN)-C identified her process to track employee illnesses was to receive a copy of each departments staff call-ins, review and identify staff who reported sick and to and discuss at the facility's morning meetings. RN-C was to call those employees who was sick, identify the illnesses reported and determine if further evaluation was needed, depending on the employee's symptoms and risk of transmission. RN-C identified both DA-A and NA-Y lacked appropriate tracking and surveillance of DA-A and NA-Y illnesses to determine if DA-A and NA-Y was appropriate to return back to work. Interview on 7/25/25 at 0:29 a.m., with director of nursing (DON) expectations was for the infection preventionist (IP) or designee, to track, monitor and identify when employee's symptoms resolved and when it was appropriate for employees to return to work. Review of December 2024, Communicable/Contagious Disease, Employee policy identified facility staff who was active with communicable infections, was not to be in contact with residents, resident environment, residents care items and equipment until they were no longer contagious. The IP was to oversee employee health practices, including work restrictions and return to work criteria. In addition, employees was responsible to report suspected or confirmed infections with communicable or infectious disease to their supervisor upon onset and/or prior to reporting to their scheduled shifts. Review of April 2025, Facility assessment identified the facility's infection prevention department was to implement protocols to execute and ensure accurate tracking and mapping of the spread of infections and complete screenings to identify when staff was a potential transmitter of infections and/or communicable diseases.