DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 0TQH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00764

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245569**
2.STATE VENDOR OR MEDICAID NO.
(L2) **075740300**

3. NAME AND ADDRESS OF FACILITY
(L3) **HALSTAD LIVING CENTER**
(L4) **133 FOURTH AVENUE EAST**
(L5) **HALSTAD, MN** (L6) **56548**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/24/2020** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 02/12/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 02/12/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/13/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 12, 2020

CMS Certification Number (CCN): 245569

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 17, 2020 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 12, 2020

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

RE: CCN: 245569
Cycle Start Date: December 5, 2019

Dear Administrator:

On January 24, 2020, the Minnesota Department(s) of Health and Public Safety, 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0TQH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00764

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(L1) **245569**

2.STATE VENDOR OR MEDICAID NO.
(L2) **075740300**

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(L3) **HALSTAD LIVING CENTER**
(L4) **133 FOURTH AVENUE EAST**
(L5) **HALSTAD, MN** (L6) **56548**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/05/2019** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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13.Total Certified Beds **44** (L17)

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE - NE II 01/03/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/13/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 19, 2019

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

RE: CCN: 245569
Cycle Start Date: December 5, 2019

Dear Administrator:

On December 5, 2019, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

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 March 5, 2020 (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 June 5, 2020 (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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 12/2/19, through 12/5/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/2/19 thru 12/5/19 a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found substantiated: H5569007C. Deficiencies were issued at 609 and 610. The following complaint were found unsubstantiated: H5569008C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with	F 000		

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

Electronically Signed | 12/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

(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	Continued From page 1 your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of physical abuse was immediately reported to the administrator and immediately reported to the	F 609	It is the policy of Halstad Living Center that reports of all types of abuse are promptly reported and thoroughly investigated.	1/15/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

(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 609	Continued From page 2 State Agency (SA) , no later than two hours, for 1 of 1 residents (R85) reviewed for abuse. Findings include: R85's significant change Minimum Data Set (MDS) dated 8/20/19, indicated R85 had diagnoses which included coronary artery disease, dementia, depression. The MDS indicated R85 had severe cognitive impairment, required extensive assistance of two staff transfers, extensive assistance of one staff for bed mobility, dressing, toileting, personal hygiene and bathing. On 12/5/19 at 9:06 a.m. during a telephone interview with nursing assistant (NA)-C. NA-C indicated she and the alleged perpetrator(AP) had been attempting to put residents to bed after supper and R27 needed one on one supervision due to being a fall risk and repeatedly trying to get up out of his wheel chair. NA-C indicated the AP got frustrated with R27 trying to get up out of his wheel chair all the time and the AP took two gait belts, hooked them together, placed it around R27's waist and hooked it behind the back of R27's wheel chair. NA-C indicated the incident happened on a weekend around 7:00 or 8:00 p.m. in July. NA-C indicated she had not reported the incident to anyone working with her that shift but had placed a note in the director of nursing (DON) mailbox regarding the incident. NA-C indicated she had also reported the incident a few weeks later to licensed practical nurse (LPN)-B during a scheduling discussion. On 12/5/19 at 9:30 a.m. LPN-B confirmed NA-C had reported AP had used two gaits hooked together to restrain R27 in his wheelchair. LPN-B	F 609	Staff member NA-C was immediately educated on the policy for reporting potential abuse and how to reach the Director/Supervisor on call. All residents in the facility have the potential to be impacted by this practice. All staff will be provided training on reporting suspected abuse or neglect, whom to make these reports to, timeliness of these reports and the assignment that all Care Center Employees are Mandated Reporters. The DON/designee will review all State Agency reported abuse allegations to ensure the facility reported the allegation in a timely manner for 1 month, then 3 audits/month for 2 months, then monthly thereafter until 100% compliance is attained and maintained. In addition, DON/designee will conduct observation and audits of cares, and interviews of staff and residents regarding care practices 3 times per month for 2 months, then monthly thereafter to ensure that any concern of abuse has been reported timely and investigations conducted thoroughly. This will continue until 100% compliance is attained and maintained. Audits will be reported to the Quality Assurance Committee and QAPI Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 3	F 609		

indicated NA-C reported this had occurred on 7/7/19 around 6:30 p.m. after supper. LPN-A indicated NA-A reported the incident to her on 7/20/19 and LPN-B then reported the incident again to the DON.

The facility provided a copy of R85's Incident Report #327836, submitted to the SA on 7/20/19 at 12:12 p.m. which listed an allegation of physical abuse with use of manual or physical restraints and listed the incident had occurred on 7/20/19 at 11:00 a.m. in the sitting area of the nursing home. The report indicated staff had reported the incident happen on a previous shift and AP restrained R85 in his wheel chair using gait belts.

On 12/5/19 at 11:37 a.m. the DON confirmed the above findings and indicated a allegation of physical abuse involving a staff member restraining R85 in his wheel chair using gait belts occurred on 7/7/19. The DON indicated she had not received a note from NA-C in her box regarding the incident and NA-C had not reported the incident to other licensed staff until 7/20/19. She confirmed she would expect all staff to immediately report the allegation of abuse to licensed staff and the facility would report the allegation of abuse within 2 hours to the SA.

On 12/5/19 at 11:50 a.m. the administrator confirmed the above findings and indicated the allegation of physical abuse of restraining R85 in his wheelchair with gait belts occurred on 7/7/19 and she had been notified on 7/20/19. The administrator confirmed the allegation of abuse was reported late and she would expect staff to follow the facility policy and to report the allegation of abuse immediately, within 2 hours to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 4 the SA. Review of facility policy titled, Vulnerable Adult and Abuse and Neglect Prevention revised on 8/17, indicated it is the policy of Halstad Living Center that reports of "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per federal and state law. The facility will ensure that all alleged violations involving abuse, neglect exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but no later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the state survey agency and adult protection services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures. It is the policy of Halstad Living Center that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		1/15/20

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F 610	Continued From page 5 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a thorough investigate regarding an allegation of physical abuse for 1 of 1 resident (R85) reviewed for abuse. Findings include: R85's significant change Minimum Data Set (MDS) dated 8/20/19, indicated R85 had diagnoses which included coronary artery disease, dementia, depression and was severely cognitively impaired. The MDS indicated 85 required extensive assistance of two staff transfers, extensive assistance of one staff for bed mobility, dressing, toileting, personal hygiene and bathing. On 12/5/19 at 9:06 a.m. during a telephone interview with nursing assistant (NA)-C. NA-C indicated she and the alleged perpetrator(AP) had been attempting to put residents to bed after supper and R27 needed one on one supervision due to being a fall risk and repeatedly trying to get up out of his wheelchair. NA-C indicated the AP	F 610	It is the policy of Halstad Living Center to promptly and thoroughly investigation all allegations of abuse. Upon discovery of the area of concern,other residents and staff were interviewed to determine if they had observed any other similar instances experienced by residents. The AP was not suspended during the investigation due to AP was not scheduled to work for the next five days, at which time the investigation took place. The AP was immediately terminated following report of the incident and upon immediate surveillance video review on 7/20/19. All residents in the facility have the potential to be impacted by this practice. Staff involved with investigating potential complaints were re-educated on completing a thorough investigation and protecting residents after an allegation of abuse occurs. Upon identification of the area concern during annual survey, a new investigation tool was created for staff and they were	

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F 610	Continued From page 6 got frustrated with R27 trying to get up out of his wheelchair all the time and the AP took two gait belts, hooked them together, placed it around R27's waist and hooked it behind the back of R27's wheelchair. NA-C indicated the incident happened on a weekend in July, around 7:00 or 8:00 p.m. NA-C indicated she had not reported the incident to anyone working with her that shift but had placed a note in the director of nursing (DON) mailbox regarding the incident. NA-C indicated she had also reported the incident a few weeks later to licensed practical nurse (LPN)-B during a scheduling discussion. The facility provided a copy of R85's report submitted to the SA, Incident Report #327836, submitted to the SA on 7/20/19 at 12:12 p.m. listed an allegation of physical abuse with use of manual or physical restraints and listed the incident had occurred on 11/20/19 at 11:00 a.m. in the sitting area of the nursing home. The report indicated a staff member had reported the incident happen on a previous shift and the alleged perpetrator restrained R85 in his wheel chair using gait belts. The facility provided a copy of R85's Investigation Status Report #327836, submitted to the SA on 7/25/19 at 1:34 p.m. The report indicated R85's family had been notified, staff were re-educated on use of restraints, the restraint policy and procedure was reviewed and the AP was terminated. However, the report lacked documentation the facility had interviewed other residents regarding further allegations of abuse from staff. On 12/5/19 at 12:28 p.m. LPN-B provided the facility's internal investigation which listed an	F 610	immediately educated how to use the tool to perform a thorough investigation. All staff will be re-educated further on facility abuse prevention/reporting/and investigation. The DON/designee will review all State Agency reported abuse allegations to ensure the facility thoroughly investigated and protected residents after allegation of abuse occurred for 1 month, then 3 audits/month for 2months, then monthly thereafter. Audits will be reported to the Quality Assurance Committee and QAPI Committee quarterly and as needed. The Quality Assurance Committee will make recommendations for ongoing monitoring.	

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F 610	Continued From page 7	F 610		

interview on 7/20/19 with NA-C and other staff working on the evening of 7/7/19. LPN-B indicated she had not interviewed all the staff that was working that evening and had not interviewed other residents or visitors regarding the allegation of abuse. No further information regarding the investigation was provided.

On 12/5/19 at 11:37 a.m. the DON confirmed the above findings and indicated the incident with R85 should of been thoroughly investigated. The DON indicated she would expect staff to follow the abuse prevention policy and to complete a thorough investigation which included interviewing staff, other residents and visitors regarding potential abuse by staff.

On 12/5/19 at 11:50 a.m. the administrator confirmed the above findings and indicated she would expect staff to follow the facility policy. The administrator indicated staff should of done a thorough investigation and should of talked to more staff about the incident and should of talked to visitors and other residents that may have seen something.

Review of facility policy titled, Vulnerable Adult and Abuse and Neglect Prevention revised on 8/17, indicated it is the policy of Halstad Living Center that reports of "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per federal and state law. The facility will ensure that all alleged violations involving abuse, neglect exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but no later that 2 hours after the allegation is made,

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F 610	Continued From page 8 if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the state survey agency and adult protection services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures. It is the policy of Halstad Living Center that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated.	F 610		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		1/17/20

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F 791	Continued From page 9 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide arrangements for follow up care with a dentist for 1 of 1 residents (R20) reviewed for dental care. Findings include: R20's annual Minimum Data Set (MDS) dated 10/4/19, identified R20 had diagnoses which included coronary artery disease, high blood pressure anxiety and was cognitively intact. The MDS identified R20 required extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene and total dependence with bathing tasks. The MDS indicated R20 had a weight loss, had abnormal mouth tissue and	F 791	It is the policy of Halstad Living Center that we must assist residents in obtaining routine and 24-hour emergency dental care. Based on observation, interview and document review, the Halstad Living Center failed to provide arrangements for follow up care with a dentist for 1 of 1 residents (R20) reviewed for dental care. Immediate education regarding facility policy on resident dental services via verbal communication from the DON was provided to all nursing staff that assist residents with setting up dental care needs on 12/4/19. Immediate action was taken on 12/4/19 and R20 was offered these dental services, in which R20 stated	

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F 791	Continued From page 10 obvious or likely cavity or broken natural teeth. R20's annual Care Area Assessment (CAA) dated 10/5/19, identified R20 required assistance with most activities of daily living (ADL's) due to generalized weakness. The CAA identified R20 had multiple missing teeth/caries and thrush. R20's care plan revised on 10/10/19, identified R20 required extensive assistance with personal hygiene. The care plan identified R20 had her own teeth and required oral inspections quarterly. On 12/2/19, at 6:42 p.m. R20 was observed lying in bed watching TV. R20 smiled and revealed several missing teeth from her upper and lower palates. R20 stated she had several teeth that had been pulled by a dentist. R20 stated there had been no discussion with the facility staff regarding scheduling a dental visit for follow-up dental work. Review of R20's facility form titled Oral Health Assessment dated 9/29/19, revealed R20 had obvious or likely cavity or broken natural teeth. The form indicated R20 had been to the dentist prior to admission and had some of her teeth pulled. Further, the form indicated R20 had planned to get fitted for partials and had not been back to the dentist prior to admission. Review of R20's oral/dental assessment form dated 10/28/19, indicated R20 had obvious or likely cavity or broken natural teeth. The form identified R20 had natural teeth present with several root tips visualized on top and bottom. Further, the form identified R20 had been interested in seeing a dentist for an exam and cleaning.	F 791	she would like to wait until there is a dentist in-house. R20 doesn't have any pain or issues with the few teeth that she has. All nursing staff will be re-educated that the Halstad Living Center is responsible for assisting the residents and/or family in making a dental appointment and transportation arrangements as necessary. In addition, re-education on the Halstad Living Center's Dental Services Policy and Procedure on or before 1/17/2020. Visual audits have been completed by the DON on all current resident charts to verify all dental follow-ups are up to date/in place and/or scheduled if needed. Then visual audits will be completed by DON or designee on random residents after the admission oral assessment is completed, after a dental visit and/or an Oral Health Screen for 1 month and randomly thereafter to ensure proper follow up on dental appointments are provided for all residents. Results of the audits will be reviewed by the QA and QAPI committees until 100% compliance is attained and maintained.	

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On 12/4/19, at 11:58 a.m. licensed practical nurse (LPN)-A stated R20 had missing natural teeth and had never expressed a desire to be seen by a dentist. LPN-A stated the LPN in medical records (MR) made appointments for residents to be seen by the dentist and further stated the dentist made visits twice a year to the facility.

On 12/4/19, at 1:22 p.m. registered nurse (RN)-A stated the RN's competed the oral health assessments in the facility and if a resident had a need or desire to see a dentist the LPN in MR would have scheduled the appointments. RN-A stated there had been an expectation for the appointment to have been scheduled within 24 hours after a request had been made. RN-A reviewed R20's electronic health record (EHR) and verified R20 had expressed a desire to be fitted for partial dentures upon admission. Further, RN-A verified R20 had been seen by a dental hygienist on 10/28/19, and R20 had expressed an interest in seeing a dentist for an exam and cleaning. RN-A verified there had been no dental appointment made for R20.

On 12/4/19, at 1:56 p.m. LPN in MR (LPNMR)-C stated nursing staff reported to her when an a dental appointment should have been made. LPNMR-C reviewed R20's EHR and verified she had not scheduled a dental appointment for R20. LPNMR-C verified an appointment should have been made upon R20's first request which had been made upon R20's admission to the facility.

On 12/4/19, at 2:15 p.m. director of nursing (DON) stated her expectation was the facility would have made an a dental appointment within three days of R20's request. The DON confirmed

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F 791	Continued From page 12 a dental appointment had not been made for R20 as requested. Review of facility policy titled Dental Services revised 10/2019, identified if an oral issue had been identified, the nursing staff needed to discuss dental care and a dental appointment with the resident or family within three days of the finding. Further, the policy identified the facility had been responsible for assisting the resident and or family in making a dental appointment and transportation arrangements as necessary.	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food items	F 812	Food and beverages found not labeled and/or dated. Policy in place has been	1/14/20

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F 812	Continued From page 13 were properly stored and dated for 1 of 1 kitchens of the facility. In addition, the facility failed to ensure 1 of 1 ice and water machines was properly cleaned and sanitized in the facility. Further, the facility failed to serve food in a sanitary manner during 1 of 1 observation of food service of the supper meal when staff did not properly utilize hairnets when serving residents food. This deficient practice had the potential to affect 38 residents that received food from the kitchen and received water from the ice and water machine. Findings include: On 12/2/19 at 1:50 p.m.. during an initial tour of the facility kitchen area with dietary manager (DM) the following concerns were identified: Drink Refrigerator: - 3 individual plastic containers of food which held meatloaf, dumplings and vegetable on the lower shelf of fridge and was undated. -1 large silver container covered with tin foil with a handwritten note on the top of the tin foil "dumplings" and undated. Walk in Cooler: - five one half gallons of milk with expiration date of 11/27/19 and one was half full and the other four were full. - a large bag of shredded cheese, which was opened and one quarter full was not dated. - a bag of prunes with the outside wrapper very sticky and expiration date of 6/22/19. - a large bag of lettuce salad mixture, which was opened and one half full was not dated. DM confirmed the above findings and removed	F 812	reviewed and updated. All dietary employees will be trained on this policy Tuesday, January 14, 2020 by the Consultant Dietitian. Monitoring of all food storage areas for food items that don't comply with dating/labeling policy will be added to the weekly cleaning schedule. Three random audits will be completed by CDM on a weekly basis for 1 month to monitor for foods/fluids not dated/labeled. If foods/fluids are found not to be labeled during the first month, the audits will continue for consecutive months until no foods/fluids are found to be unlabeled. Audits to begin immediately. CDM will complete on the spot and continual coaching with staff to assure consistent labeling/dating of foods/beverages. CDM will report findings at the QA and/or QAPI meeting. Ice/water machine found to have lime build-up and rust in various areas. A new ice machine will be purchased and in place by January 31, 2020. Dietary and Maintenance staff will be trained on the attached ice/water machine cleaning policy by Monday, December 30, 2019. This policy will be followed until a new ice/water machine is in place. The policy will be updated once the new policy is in place and all Dietary and Maintenance staff will be trained again on the updated policy. Three random audits will be completed on a weekly basis for 1 month by the CDM and Maintenance Director to monitor for appropriate cleaning and de-liming of ice machine. If any issues with the cleanliness of the ice/water machine are found during the first month,	

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F 812	Continued From page 14 the undated and expired food items and discarded them. On 12/2/19, at 2:10 p.m. during observations of the dining room, the ice and water machine located on the counter in the dining room had heavy encrusted hard water lime scale build up with flakes and rust under the dispenser and the tray area of the ice and water machine. The ice and water machine was also leaking water onto the counter. ICE MACHINE On 12/4/19 at 11:28 a.m. during a tour of the kitchen with the DM the following concerns were identified: - the ice and water machine located in the dining room area of the facility, continued to have heavy encrusted hard water lime scale build up with flakes and rust under the dispenser and the tray area of the ice and water machine. The ice and water machine was also leaking water onto the counter. The DM confirmed the above findings and indicated staff clean the ice and water machine weekly and de-scale it weekly. The DM indicated staff had just cleaned the ice and water machine that day. On 12/4/19 at 11:52 a.m. the DM indicated the lettuce, cheese, prunes, dumplings, containers of food should be labeled and dated when opened. The DM also indicated she would expect staff to not to use products with expired dates and indicated these items were not safe to serve when expired and should be discarded. The DM indicated the facility had issues with the ice and	F 812	the audits will continue for consecutive months until no issues are found. The CDM and Maintenance Director will re-train staff if audit inspections show ice/water machine has not been cleaned or de-limed appropriately. The CDM and Maintenance Director will report findings at the QA and/or QAPI meeting. Hair restraints not use appropriately. Policy in place has been updated to be more specific concerning use of hair restraints. All dietary employees will be trained on updated policy on Tuesday, January 14, 2020 by Consultant Dietitian. Three random audits will be completed by the CDM on a weekly basis for 1 month to monitor for appropriate use of hair restraints. Audits to begin immediately. If any issues with the appropriate use of hair restraints are found during the first month, the audits will continue for consecutive months until no issues are found. The CDM will complete on the spot and continual coaching with staff to assure consistent and appropriate use of hair restraints. The CDM will report findings at the QA and/or QAPI meeting.	

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F 812	Continued From page 15	F 812		

water machine for sometime, but would expect staff to clean it and indicated maybe staff needed to try something else.

On 12/4/19 at 11:58 a.m. the maintenance supervisor (MS) confirmed the ice machine had lime scale build up and currently leaked water. The MS indicated staff were responsible for cleaning the ice and water machine monthly and did not think the lime scale build up was a health concern. The MS indicated he could not control the lime scale build up on the ice and water machine and it was currently leaking. The MS confirmed he had no cleaning schedules for the ice and water machine and no policies.

Food service:
On 12/2/19, at 5:18 p.m. a portable steam table was observed parked just outside the kitchen entrance in the facility dining room. Dietary cook (DC)-A placed trays into the steam table including; chicken fajita, meat sauce, cauliflower, ravioli, and mashed potatoes.

On 12/2/19, at 5:22 p.m. DC-A donned gloves and was observed to wear a hair net covering her pony tail only. DC-A had long pieces of brown shoulder length hair hanging down around her face with a hair net that only covered the pony tail portion of her head. DC-A dished the first plate and handed the plate of food items to dietary assistant (DA)-A. DA-A took the plate from DC-A and walked the plate to a resident seated at a table in the dining room. DA-A was observed to be wearing a beard restraint and a hairnet that only covered the longer hair on the top part of his head with the bottom half of his head and hair exposed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

(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 812	Continued From page 16	F 812		

On 12/2/19, at 5:55 p.m. DA-A was setting up room trays for individual residents in the kitchen area. DA-A stated he wore a beard net and hairnet to prevent hair from falling into the food and stated he normally wore his hairnet on only the long hairs on the top of his head and left the bottom half of his head and hair exposed.

On 12/2/19, at 6:01 p.m. DC-A stated she usually wore her hair in a pony tail or bun and verified her hair was hanging loose around her face, not covered by a hairnet when she was serving food. She indicated her hair should have been covered when she worked with food.

On 12/2/19, at 6:03 p.m. DM stated it was the normal practice for staff to cover their hair when they enter the kitchen or handle food, and would expect hair to be covered at all times. The DM stated she had not noticed that DC-A had her hair hanging down while she served the food to the residents for supper. DM stated hairnets were to be worn to keep hair contained and out of the food, and all hair should be covered.

Review of facility policy titled, Cleaning of Coffee Maker, Juice Machine, Ice Machine, Ice Cream Machine dated 8/15/19, indicated the coffee maker, juice machine, ice machine and ice cream machine will be cleaned thoroughly following the manufactures instructions.

Review of facility policy titled, Food Dating and Handling of expired foods dated 8/15/19, indicated the best practice for a date marking system would be to include a tabled with the product name, the day or date, and time is was prepared for opened. Follow state or local health

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F 812	Continued From page 17 department requirements. A review of the facility provided policy and procedure dated 8/21/2013, and titled "Preventing Food Born Illness", described various implementations to prevent food born illness including number 12. hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens.	F 812		
F 880 SS=C	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		1/17/20

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F 880	Continued From page 18 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review and/or revise the infection control program's policies and procedures annually. This deficient practice had the potential to affect all 38 residents currently residing in the facility. Findings include: A review of the facility's infection control program was conducted on 12/5/19, at 11:18 a.m. with the infection control coordinator (ICC) present. The facility provided copies of policies and procedures associated with the infection control program. A review of the policies and procedures indicated a lack of an annual review. The ICC stated the policies and procedures should have been reviewed annually at the quality assurance meetings. Further, the ICC stated the review date was documented on each policy and procedure at the top right corner of each policy. The ICC reviewed the policies and procedures and verified the policies and procedures had not been reviewed annually. Review of the infection control program's policies and procedures revealed the following: - The facility policy titled Infection Prevention and Control Program had last been reviewed on 4/10/18. - The facility policy titled Infection Surveillance (Process/Outcome/Recording/Reporting) had last been reviewed on 5/16/18. - The facility policy titled Employee Training on Infection Control had last been reviewed on 4/10/18.	F 880	It is the policy of Halstad Living Center that there is an established infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. In addition, the Halstad Living Center will conduct an annual review (and as needed) of its Infection Control Program Policies and Procedures. Based on interview and document review, the Halstad Living Center failed to review and/or revise the infection control program's policies and procedures annually. This deficient practice had the potential to affect all 38 residents currently residing in the facility. Immediate education regarding facility policy on Annual Review of Infection Control Policies and Procedures was provided to the Infection Preventionist on 12/5/19 via verbal communication from the DON. All staff will be re-educated that Infection Control Policies and Procedures are updated annually on or before 1/17/2020. All Infection Control Policies and Procedures will be reviewed and/or revised no later than 12/31/2019. Infection Control Policies and Procedures that were revised will be reviewed by the QA and QAPI committees, with 100% compliance attained on all infection control policies and procedures being reviewed.	

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F 880	Continued From page 20	F 880		

- The facility policy titled Infection Prevention and Control Committee had last been reviewed on 4/10/18.
- The facility policy titled Infection Prevention and Control Program had last been reviewed on 4/10/18.
- The facility policy titled Infection Preventionist had last been reviewed on 4/10/18.
- The facility policy titled Outbreak of Communicable Diseases had last been reviewed on 4/11/18.
- The facility policy titled Antibiotic Stewardship had last been revised on 5/3/18.
- The facility policy titled Contact Precautions had last been reviewed on 5/18/18.
- The facility policy titled Personal Protective Equipment PPE had last been reviewed on 5/11/18.
- The facility policy titled Laundry- Infection Control had last been reviewed on 7/2018.

On 12/5/19, at 12:06 p.m. the director of nursing (DON) stated it had been expected all policies and procedures in the infection control program had been reviewed annually in the facility's quality assurance committee. DON confirmed the infection control policies and procedures had not been reviewed annually.

Review of the facility policy titled Infection Prevention and Control Program revised on 4/10/18, identified the policies and procedures had been utilized as the standards of the infection prevention and control program. Further, the policy indicated the infection prevention and control committee reviewed the policies annually. Additionally, the policy identified the annual review would have included updating or supplementing policies as needed, an

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F 880	Continued From page 21 assessment of staff compliance with existing policies and any trends or significant problems since the previous review.	F 880		

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	245569	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2019**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshal Division. At the time of this survey Halstad Living Center 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/27/2019

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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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Halstad Living Center was built in 1977 as a 1-story building without a basement and was determined to be Type II (000) construction. In 1990 a 1-story addition to the dining room was constructed to the east of the original building and was determined to be Type II (111) construction. In 1998 a dining addition was constructed to the west of 200 wing and an addition to the south to connect to the apartment building. These additions are 1 story without a basement and were determined to be of a Type II (111) construction. The building is divided into 5 smoke zones with 1/2 hour fire rated barriers. The entire building is sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common	K 000		

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K 000	Continued From page 2 areas, installed in accordance with NFPA 72 "The National Fire Alarm Code". Hazardous areas have automatic fire detectors that are on the fire alarm system. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building. The facility has a capacity of 44 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		12/3/19

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K 353	Continued From page 3 by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of staff and visitors. Findings include: During the facility tour between 8:30 am to 12:30 pm on 12/3/2019 observations revealed the storage in activities room 93 A was too close to the sprinkler deflector. This deficient condition was confirmed by the Director of Maintenance.	K 353	It is the policy of Halstad Living Center to maintain the sprinkler system in accordance with the 2012 Life Safety Codes. The deficient practice was identified on 12/3/19. Maintenance staff immediately following inspection removed all items from the top shelf of the storage room of activities room 93A and also completed removed the top shelf to further prevent items from being stacked too high going forward.	
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility allowed the use of a portable space heater not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.8. This deficient practice could affect 15 of the 44 residents and an undetermined amount of staff	K 781	It is the policy of Halstad Living Center to maintain compliance with Life Safety Code 2012. Upon identification of the deficient practice maintenance staff obtained resident and resident family's permission to disable the elements and	12/4/19

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K 781	Continued From page 4 and visitors. Findings include: During the facility tour between 8:30 am to 12:30 pm on 12/3/2019 observations revealed an electric fireplace style heater in resident room 309. This deficient condition was confirmed by the Director of Maintenance.	K 781	remove the power cord of the space heater in room 309.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		12/4/19

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K 920	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2..4.2.1 and the use of power strips comply with 10.2.3.6. This deficient practice could affect an undetermined amount of residents, staff and visitors. Findings include: During the facility tour between 8:30 am to 12:30 pm on 12/3/2019 observations revealed an unlisted power strip in use in resident room 305. This deficient condition was confirmed by the Director of Maintenance.	K 920	It is the policy of Halstad Living Center to maintain compliance with 2012 Life Safety Codes. The unlisted power strip in room 305 was immediately removed and replaced with new power strip that is UL listed and labeled RELOCATABLE POWER TAP.	

Electronically delivered
December 19, 2019

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

Re: State Nursing Home Licensing Orders
Event ID: 0TQH11

Dear Administrator:

The above facility was surveyed on December 2, 2019 through December 5, 2019 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	133 FOURTH AVENUE EAST HALSTAD, MN 56548

(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
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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/2/19, to 12/5/19, surveyors of this Department's staff visited the above provider and the following correction orders are issued. In addition, a complaint investigation was conducted. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. The following complaint were found unsubstantiated: H5569008C The following complaint were found substantiated: H5569007C. Order issued at 1980. 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	2 000		

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2 000	Continued From page 2 after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		
2 995	MN Rule 4658.0610 Subp. 3 Dietary Staff Requirements -Grooming. Subp. 3. Grooming. Dietary staff must wear clean outer garments. Hairnets or other hair restraints must be worn to prevent the contamination of food, utensils, and equipment. Hair spray is not an acceptable hair restraint. This MN Requirement is not met as evidenced by: Based on observation, interview and document review th facility failed to serve food in a sanitary manner during 1 of 1 observation of food service of the supper meal when staff did not properly utilize hairnets when serving residents food. This deficient practice had the potential to affect 38 residents that received food from the kitchen and received water from the ice and water machine. Findings include:	2 995	Corrected.	1/14/20

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2 995	Continued From page 3 On 12/2/19, at 5:18 p.m. a portable steam table was observed parked just outside the kitchen entrance in the facility dining room. Dietary cook (DC)-A placed trays into the steam table including; chicken fajita, meat sauce, cauliflower, ravioli, and mashed potatoes. On 12/2/19, at 5:22 p.m. DC-A donned gloves and was observed to wear a hair net covering her pony tail only. DC-A had long pieces of brown shoulder length hair hanging down around her face with a hair net that only covered the pony tail portion of her head. DC-A dished the first plate and handed the plate of food items to dietary assistant (DA)-A. DA-A took the plate from DC-A and walked the plate to a resident seated at a table in the dining room. DA-A was observed to be wearing a beard restraint and a hairnet that only covered the longer hair on the top part of his head with the bottom half of his head and hair exposed. On 12/2/19, at 5:55 p.m. DA-A was setting up room trays for individual residents in the kitchen area. DA-A stated he wore a beard net and hairnet to prevent hair from falling into the food and stated he normally wore his hairnet on only the long hairs on the top of his head and left the bottom half of his head and hair exposed. On 12/2/19, at 6:01 p.m. DC-A stated she usually wore her hair in a pony tail or bun and verified her hair was hanging loose around her face, not covered by a hairnet when she was serving food. She indicated her hair should have been covered when she worked with food. On 12/2/19, at 6:03 p.m. DM stated it was the normal practice for staff to cover their hair when they enter the kitchen or handle food, and would	2 995		

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2 995	Continued From page 4 expect hair to be covered at all times. The DM stated she had not noticed that DC-A had her hair hanging down while she served the food to the residents for supper. DM stated hairnets were to be worn to keep hair contained and out of the food, and all hair should be covered. A review of the facility provided policy and procedure dated 8/21/2013, and titled "Preventing Food Born Illness", described various implementations to prevent food born illness including number 12. hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could ensure appropriate is maintained by dietary staff in the kitchen and food service. The facility could update or create policies and procedures, and educate staff on these changes. The dietary manager or designee could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 995		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and	21095		1/14/20

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21095	Continued From page 5 other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food items were properly stored and dated for 1 of 1 kitchen of the facility. In addition, the facility failed to ensure 1 of 1 ice and water machines was properly cleaned and sanitized in the facility. This deficient practice had the potential to affect all 38 residents residing in the faclity. Findings include: On 12/2/19 at 1:50 p.m.. during an initial tour of the facility kitchen area with dietary manager (DM) the following concerns were identified: Drink Refrigerator: - 3 individual plastic containers of food which held meatloaf, dumplings and vegetable on the lower shelf of fridge and was undated. -1 large silver container covered with tin foil with a handwritten note on the top of the tin foil "dumplings" and undated. Walk in Cooler: - five one half gallons of milk with expiration date	21095	Corrected.	

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21095	Continued From page 6 of 11/27/19 and one was half full and the other four were full. - a large bag of shredded cheese, which was opened and one quarter full was not dated. - a bag of prunes with the outside wrapper very sticky and expiration date of 6/22/19. - a large bag of lettuce salad mixture, which was opened and one half full was not dated. DM confirmed the above findings and removed the undated and expired food items and discarded them. On 12/2/19, at 2:10 p.m. during observations of the dining room, the ice and water machine located on the counter in the dining room had heavy encrusted hard water lime scale build up with flakes and rust under the dispenser and the tray area of the ice and water machine. The ice and water machine was also leaking water onto the counter. ICE MACHINE On 12/4/19 at 11:28 a.m. during a tour of the kitchen with the DM the following concerns were identified: - the ice and water machine located in the dining room area of the facility, continued to have heavy encrusted hard water lime scale build up with flakes and rust under the dispenser and the tray area of the ice and water machine. The ice and water machine was also leaking water onto the counter. The DM confirmed the above findings and indicated staff clean the ice and water machine weekly and de-scale it weekly. The DM indicated staff had just cleaned the ice and water machine that day.	21095		

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21095	Continued From page 7 On 12/4/19 at 11:52 a.m. the DM indicated the lettuce, cheese, prunes, dumplings, containers of food should be labeled and dated when opened. The DM also indicated she would expect staff to not to use products with expired dates and indicated these items were not safe to serve when expired and should be discarded. The DM indicated the facility had issues with the ice and water machine for sometime, but would expect staff to clean it and indicated maybe staff needed to try something else. On 12/4/19 at 11:58 a.m. the maintenance supervisor (MS) confirmed the ice machine had lime scale build up and currently leaked water. The MS indicated staff were responsible for cleaning the ice and water machine monthly and did not think the lime scale build up was a health concern. The MS indicated he could not control the lime scale build up on the ice and water machine and it was currently leaking. The MS confirmed he had no cleaning schedules for the ice and water machine and no policies. Review of facility policy titled, Cleaning of Coffee Maker, Juice Machine, Ice Machine, Ice Cream Machine dated 8/15/19, indicated the coffee maker, juice machine, ice machine and ice cream machine will be cleaned thoroughly following the manufactures instructions. Review of facility policy titled, Food Dating and Handling of expired foods dated 8/15/19, indicated the best practice for a date marking system would be to include a tabled with the product name, the day or date, and time is was prepared for opened. Follow state or local health department requirements.	21095		

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21095	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The dietary director could review and revise food storage policies and procedures and policies and procedures for cleaning of the ice/water machine. They could provide education to appropriate staff and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21355	MN Rule 4658.0730 Subp. 3 NH Dental Requirements; Making appointment Subp. 3. Making appointments. A nursing home must assist residents in making dental appointments and arranging for transportation to and from the dentist's office. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide arrangements for follow up care with a dentist for 1 of 1 residents (R20) reviewed for dental care. Findings include: R20's annual Minimum Data Set (MDS) dated 10/4/19, identified R20 had diagnoses which included coronary artery disease, high blood pressure anxiety and was cognitively intact. The MDS identified R20 required extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene and total dependence with bathing tasks. The MDS indicated R20 had a weight loss, had abnormal mouth tissue and obvious or likely cavity or broken natural teeth.	21355	Corrected.	1/17/20

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21355	Continued From page 9 R20's annual Care Area Assessment (CAA) dated 10/5/19, identified R20 required assistance with most activities of daily living (ADL's) due to generalized weakness. The CAA identified R20 had multiple missing teeth/caries and thrush. R20's care plan revised on 10/10/19, identified R20 required extensive assistance with personal hygiene. The care plan identified R20 had her own teeth and required oral inspections quarterly. On 12/2/19, at 6:42 p.m. R20 was observed lying in bed watching TV. R20 smiled and revealed several missing teeth from her upper and lower palates. R20 stated she had several teeth that had been pulled by a dentist. R20 stated there had been no discussion with the facility staff regarding scheduling a dental visit for follow-up dental work. Review of R20's facility form titled Oral Health Assessment dated 9/29/19, revealed R20 had obvious or likely cavity or broken natural teeth. The form indicated R20 had been to the dentist prior to admission and had some of her teeth pulled. Further, the form indicated R20 had planned to get fitted for partials and had not been back to the dentist prior to admission. Review of R20's oral/dental assessment form dated 10/28/19, indicated R20 had obvious or likely cavity or broken natural teeth. The form identified R20 had natural teeth present with several root tips visualized on top and bottom. Further, the form identified R20 had been interested in seeing a dentist for an exam and cleaning. On 12/4/19, at 11:58 a.m. licensed practical nurse	21355		

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21355	Continued From page 10	21355		

(LPN)-A stated R20 had missing natural teeth and had never expressed a desire to be seen by a dentist. LPN-A stated the LPN in medical records (MR) made appointments for residents to be seen by the dentist and further stated the dentist made visits twice a year to the facility.

On 12/4/19, at 1:22 p.m. registered nurse (RN)-A stated the RN's competed the oral health assessments in the facility and if a resident had a need or desire to see a dentist the LPN in MR would have scheduled the appointments. RN-A stated there had been an expectation for the appointment to have been scheduled within 24 hours after a request had been made. RN-A reviewed R20's electronic health record (EHR) and verified R20 had expressed a desire to be fitted for partial dentures upon admission. Further, RN-A verified R20 had been seen by a dental hygienist on 10/28/19, and R20 had expressed an interest in seeing a dentist for an exam and cleaning. RN-A verified there had been no dental appointment made for R20.

On 12/4/19, at 1:56 p.m. LPN in MR (LPNMR)-C stated nursing staff reported to her when an a dental appointment should have been made. LPNMR-C reviewed R20's EHR and verified she had not scheduled a dental appointment for R20. LPNMR-C verified an appointment should have been made upon R20's first request which had been made upon R20's admission to the facility.

On 12/4/19, at 2:15 p.m. director of nursing (DON) stated her expectation was the facility would have made an a dental appointment within three days of R20's request. The DON confirmed a dental appointment had not been made for R20 as requested.

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21355	Continued From page 11 Review of facility policy titled Dental Services revised 10/2019, identified if an oral issue had been identified, the nursing staff needed to discuss dental care and a dental appointment with the resident or family within three days of the finding. Further, the policy identified the facility had been responsible for assisting the resident and or family in making a dental appointment and transportation arrangements as necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure dental referrals are completed in a timely manner. The DON or designee could educate facility staff regarding facility process for completing dental and dental care in a timely manner. The DON or designee could audit resident records to identify dental care are completed timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21355		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the	21990		1/15/20

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21990	Continued From page 12 incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of physical abuse was immediately reported to the State Agency (SA) , no later than two hours, for 1 of 1 residents (R85) reviewed for abuse. Findings include: R85's significant change Minimum Data Set (MDS) dated 8/20/19, indicated R85 had diagnoses which included coronary artery disease, dementia, depression. The MDS indicated R85 had severe cognitive impairment, required extensive assistance of two staff transfers, extensive assistance of one staff for bed mobility, dressing, toileting, personal hygiene and bathing. On 12/5/19 at 9:06 a.m. during a telephone interview with nursing assistant (NA)-C. NA-C indicated she and the alleged perpetrator(AP) had been attempting to put residents to bed after supper and R27 needed one on one supervision due to being a fall risk and repeatedly trying to get up out of his wheel chair. NA-C indicated the AP got frustrated with R27 trying to get up out of his wheel chair all the time and the AP took two gait belts, hooked them together, placed it around R27's waist and hooked it behind the back of R27's wheel chair. NA-C indicated the incident	21990	Corrected.	

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21990	Continued From page 13	21990		

happened on a weekend around 7:00 or 8:00 p.m. in July. NA-C indicated she had not reported the incident to anyone working with her that shift but had placed a note in the director of nursing (DON) mailbox regarding the incident. NA-C indicated she had also reported the incident a few weeks later to licensed practical nurse (LPN)-B during a scheduling discussion.

On 12/5/19 at 9:30 a.m. LPN-B confirmed NA-C had reported AP had used two gaits hooked together to restrain R27 in his wheelchair. LPN-B indicated NA-C reported this had occurred on 7/7/19 around 6:30 p.m. after supper. LPN-A indicated NA-A reported the incident to her on 7/20/19 and LPN-B then reported the incident again to the DON.

The facility provided a copy of R85's Incident Report #327836, submitted to the SA on 7/20/19 at 12:12 p.m. which listed an allegation of physical abuse with use of manual or physical restraints and listed the incident had occurred on 7/20/19 at 11:00 a.m. in the sitting area of the nursing home. The report indicated staff had reported the incident happen on a previous shift and AP restrained R85 in his wheel chair using gait belts.

On 12/5/19 at 11:37 a.m. the DON confirmed the above findings and indicated a allegation of physical abuse involving a staff member restraining R85 in his wheel chair using gait belts occurred on 7/7/19. The DON indicated she had not received a note from NA-C in her box regarding the incident and NA-C had not reported the incident to other licensed staff until 7/20/19. She confirmed she would expect all staff to immediately report the allegation of abuse to licensed staff and the facility would report the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: _____ B. WING _____	C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	133 FOURTH AVENUE EAST HALSTAD, MN 56548

(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
21990	Continued From page 14 allegation of abuse within 2 hours to the SA. On 12/5/19 at 11:50 a.m. the administrator confirmed the above findings and indicated the allegation of physical abuse of restraining R85 in his wheelchair with gait belts occurred on 7/7/19 and she had been notified on 7/20/19. The administrator confirmed the allegation of abuse was reported late and she would expect staff to follow the facility policy and to report the allegation of abuse immediately, within 2 hours to the SA. Review of facility policy titled, Vulnerable Adult and Abuse and Neglect Prevention revised on 8/17, indicated it is the policy of Halstad Living Center that reports of "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per federal and state law. The facility will ensure that all alleged violations involving abuse, neglect exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but no later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the state survey agency and adult protection services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures. It is the policy of Halstad Living Center that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly	21990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21990	Continued From page 15 and thoroughly investigated. The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure dental referrals are completed in a timely manner. The DON or designee could educate facility staff regarding facility process for completing dental and dental care in a timely manner. The DON or designee could audit resident records to identify dental care are completed timely. SUGGESTED METHOD OF CORRECTION: The adminstrator and/or designee could review the facility polices in regards to reporting of allegations of abuse to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21990		