



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 20, 2026

Administrator
Halstad Living Center
133 FOURTH AVENUE EAST
HALSTAD, MN 56548

RE: CCN: 245569

Cycle Start Date: May 13, 2026

Dear Administrator:

On May 13, 2026, 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 August 13, 2026 (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 November 13, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245569	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER Halstad Living Center			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST , HALSTAD, Minnesota, 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
E0000	Initial Comments On 5/11/26 through 5/13/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/14/2026
F0000	INITIAL COMMENTS On 5/11/26 through 5/13/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/14/2026
F0812 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	F0812	Corrective Action for Residents Affected Upon discovery on 5/12/26, the stack of steam table pans containing moisture between the pans was immediately removed from service. The pans were rewashed, allowed to fully air dry, and stored appropriately. No residents were identified as having been adversely affected by this practice. How the Facility Will Identify Other Residents Who May Be Affected	05/14/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0812 SS = F	<p>Continued from page 1 authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(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.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review, the facility failed to store pans sanitarily manner. This had the potential to affect all 43 residents in the facility.</p> <p>Findings include: On 5/12/26 at 10:34 a.m., there was a stack of five 10-inch (in.) x 12 in. steam table pans (pans used to hold and serve food from a steam table). When the pans were separated, two of the pans had water dripping from them on to the pans below them. The dietary manager (DM) stated when the dishes were washed, they are supposed to completely air dry and should not have been stored wet. The DM stated the staff may have been in a hurry and had not allowed the pans to completely air dry. When the pans were stored wet, there was a chance for bacteria to grow in the stacked pans and potentially cause illness. During an interview on 5/13/26 at 10:51 a.m., the administrator stated all dishes in the kitchen were expected to be completely dry before they are stored. Storing dishes while still wet could allow germs and bacteria to grow and then may be passed on to the residents. The facility's Sanitation of Dishes policy dated June 2018, identified dishes and food prep equipment are not to be towel dried for potential risk of contamination. Dishware was to be stored to prevent contamination in a clean, dry area. The 2022 Food Code from the United States Food and Drug Administration (FDA) identified all dishes and prep equipment must be allowed to drain and air dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow.</p>	F0812	<p>Continued from page 1</p> <p>All residents had the potential to be affected by improperly stored food service equipment. An immediate inspection of all clean dishware, cookware, utensils, and food preparation equipment was completed to ensure items were clean, dry, and stored in a sanitary manner. Any items found to be wet or improperly stored were rewashed and allowed to air dry before storage.</p> <p>Measures Put Into Place to Ensure the Deficient Practice Does Not Recur</p> <p>The Dietary Manager educated all dietary staff on the facility's Sanitation of Dishes policy and FDA Food Code requirements regarding proper air drying and storage of dishware and food preparation equipment. Education included:</p> <p>All dishware, pans, utensils, and food preparation equipment must be completely air dried before stacking or storage.</p> <p>Towel drying of dishware is prohibited due to contamination risk.</p> <p>Staff must verify equipment is dry before placing it into storage.</p> <p>Supervisory staff will monitor compliance during dishwashing and storage processes.</p> <p>The facility reviewed and reinforced procedures for proper dishwashing, drying, and storage with all dietary employees.</p> <p>Monitoring System</p> <p>The Dietary Manager or designee will conduct audits of dishware and food preparation equipment storage:</p> <p>Five times weekly for four weeks.</p> <p>Weekly for an additional eight weeks.</p> <p>Audits will verify that cleaned items are fully air dried and stored in a sanitary manner. Any concerns</p>	05/14/2026

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F0812 SS = F		F0812	Continued from page 2 identified will be corrected immediately and staff re-educated as needed. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and determination of the need for further action. Date of Compliance: <u> 05/14/2026 </u> Responsible Person: Dietary Manager	05/14/2026

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K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/12/2026. At the time of this survey, Halstad Living Center 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>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.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> <p>Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145</p>	K0000		05/14/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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 areas, installed in accordance with NFPA 72 "The National Fire Alarm Code". Hazardous areas have automatic fire detectors that are on the fire alarm	K0000		05/14/2026

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K0000 Bldg. 01	Continued from page 2 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 44 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		05/14/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire and smoke doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, and 4.6.12, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.9. These deficient findings could have a widespread impact on residents within the facility. Findings include: On 05/12/2026 at 11:05 AM, it was revealed by observation that the smoke/fire door for the 300 wing had latching hardware that was not working	K0761	On 05/12/2026, immediately upon identification of the deficient practice, the smoke/fire doors serving the 100 Wing, 200 Wing, and 300 Wing were evaluated and adjusted to ensure the self-closing devices fully closed the doors and the latching hardware engaged properly. The doors were tested and verified to positively latch when allowed to close under normal operation. No residents were identified as being adversely affected by this finding. The Maintenance Director conducted an inspection and functional test of all smoke barrier doors, fire-rated doors, and corridor doors throughout the facility to verify that doors closed completely and positively latched when operated by the self-closing mechanism. Any deficiencies identified during the inspection were corrected immediately. The facility implemented a preventive maintenance process requiring routine inspection and testing of smoke and fire doors to verify proper operation of self-closing devices, latching hardware, hinges, and door alignment. Any deficiencies identified will be repaired promptly to maintain the integrity of fire and smoke barriers. The Maintenance Director or designee will conduct and document inspections of all smoke barrier and fire-rated doors to verify proper self-closing and positive latching: Weekly for four weeks. Monthly for two additional months. Any identified concerns will be corrected immediately and additional staff education provided as necessary.	05/14/2026

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K0761 SS = F Bldg. 01	Continued from page 3 properly when the door was closed using the self-closing device. On 05/12/2026 at 11:13 AM, it was revealed by observation that the smoke/fire door for the 200 wing had latching hardware that was not working properly when the door was closed using the self-closing device. On 05/12/2026 at 11:24 AM, it was revealed by observation that the smoke/fire door for the 100 wing had latching hardware that was not working properly when the door was closed using the self-closing device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0761	Continued from page 3 Audit results will be reviewed through the Quality Assurance and Performance Improvement (QAPI) Committee to ensure continued compliance and determine if further corrective action is necessary.	05/14/2026
K0211 SS = D Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, and 7.1.10.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/12/2026 at 11:18 AM, it was revealed by observation that tile and other construction items were stored in the 200 Wing egress pathway to the exit door. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0211	Immediately upon identification of the deficient practice, the tile and construction materials were removed, restoring the exit access pathway to unobstructed use. No residents were adversely affected by this finding. The Maintenance Director inspected all corridors, exit access pathways, and means of egress throughout the facility to ensure there were no other obstructions. He also educated staff on LSC requirements prohibiting the storage in such manner. To prevent reoccurrence, the Maintenance Director or designee will conduct audits of means of egress, including corridors, exit access pathways, and exit discharge areas weekly for four weeks, monthly for two additional months and audit findings will be reported to the QAPI committee for review and to ensure compliance.	05/14/2026
K0223 SS = D Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices	K0223	On 05/12/2026, immediately upon identification of the deficient practice, the door wedge was removed from the Housekeeping Room 417 self-closing door. The door was tested and verified to self-close and latch properly. No residents were identified as being	05/15/2026

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NAME OF PROVIDER OR SUPPLIER Halstad Living Center			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST , HALSTAD, Minnesota, 56548	
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K0223 SS = D Bldg. 01	Continued from page 4 Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain self-closing doors per NFPA 101 (2012 edition), Life Safety Code, section 19.2.2.2.7. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/12/2026 at 10:55 AM, it was revealed by observation that the self-closing door for Housekeeping Room 417 was blocked open with a door wedge and not kept in the closed position. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0223	Continued from page 4 adversely affected by this finding. The Maintenance Director conducted an inspection of all hazardous area doors, smoke barrier doors, and other self-closing doors throughout the facility to verify that doors were not blocked open and were functioning as intended. Any doors found to be improperly held open were corrected immediately. The Maintenance Director provided education to maintenance, housekeeping, nursing, and ancillary staff regarding Life Safety Code requirements for self-closing doors protecting hazardous areas. Education included the prohibition of using wedges, kick-down devices, or any other unapproved method to hold self-closing doors open. Staff were instructed that self-closing doors must remain closed unless equipped with an approved automatic hold-open device connected to the fire alarm system. The facility reinforced expectations regarding maintaining the integrity of fire and smoke barriers at all times. The Maintenance Director or designee will conduct audits of all hazardous area and self-closing doors to verify doors are unobstructed, not wedged open, and close and latch properly: Weekly for four weeks. Monthly for two additional months. Any identified concerns will be corrected immediately, and additional staff education will be provided as needed. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and follow-up to ensure ongoing compliance.	05/15/2026
K0353 SS = D Bldg. 01	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	K0353	On 05/12/2026, immediately upon identification of the deficient practice, the lint and debris were removed from the sprinkler heads located in the laundry area. The sprinkler heads were inspected and verified to be free of obstructions that could impair proper sprinkler operation. No residents were identified as being adversely affected by this finding. The Maintenance Director conducted an inspection of all sprinkler heads throughout the facility, with particular attention to areas prone to dust, lint, or	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245569	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Halstad Living Center			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST , HALSTAD, Minnesota, 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
K0353 SS = D Bldg. 01	Continued from page 5 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/12/2026 at 11:22 AM, it was revealed by observation that the sprinkler heads in the laundry area were covered in lint and debris. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	Continued from page 5 debris accumulation, including laundry, housekeeping, storage, and mechanical rooms. Any sprinkler heads found to have dust, lint, or other foreign material accumulation were cleaned immediately. The Maintenance Director educated maintenance and housekeeping staff regarding the requirement to maintain sprinkler heads free of dust, lint, paint, and other debris that could interfere with sprinkler operation. The facility revised its environmental rounds process to include inspection of sprinkler heads for cleanliness and unobstructed operation. Special attention will be given to the laundry area due to the increased potential for lint accumulation. The Maintenance Director or designee will inspect sprinkler heads throughout the facility for cleanliness and proper condition: Weekly for four weeks. Monthly for two additional months. Any identified concerns will be corrected immediately and staff re-educated as needed. The results of these inspections will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and follow-up to ensure ongoing compliance.	05/15/2026
K0920 SS = D Bldg. 01	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) assemblies 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	K0920	On 05/12/2026, immediately upon identification of the deficient practice, the white extension cord and multi-plug adapter located in Room 310 were removed from service. Electrical equipment was connected to an approved permanent receptacle or alternative compliant power source. No residents were identified as being adversely affected by this finding. The Maintenance Director conducted an inspection of resident rooms, nursing stations, offices, treatment areas, and other facility locations to identify the use of extension cords, multi-plug adapters, and other non-compliant electrical devices. Any non-compliant devices identified were removed immediately and corrected. The facility reinforced its electrical safety procedures	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245569	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Halstad Living Center			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST , HALSTAD, Minnesota, 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
K0920 SS = D Bldg. 01	<p>Continued from page 6 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.</p> <p>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to properly use extension cords per NFPA 70 (2011 edition), National Electrical Code, section 400.8(1). This deficient finding could have an isolated impact on residents within the facility.</p> <p>Findings include:</p> <p>On 05/12/2026 at 11:10 AM, it was revealed by observation that a white extension cord with a multi-plug adaptor was being used in Room 310 to provide power to electrical equipment.</p> <p>An interview with the Maintenance Director verified this deficient finding at the time of discovery.</p>	K0920	<p>Continued from page 6 and established expectations that staff notify maintenance when additional electrical outlets are needed rather than utilizing extension cords or multi-plug adapters.</p> <p>The Maintenance Director or designee will conduct electrical safety audits throughout the facility to verify that extension cords and non-compliant multi-plug adapters are not being used:</p> <p>Weekly for four weeks.</p> <p>Monthly for two additional months.</p> <p>Any identified concerns will be corrected immediately and additional staff education will be provided as needed.</p> <p>Audit results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure ongoing compliance and determine if further corrective action is necessary.</p>	05/15/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 26, 2026

Administrator
Halstad Living Center
133 FOURTH AVENUE EAST
HALSTAD, MN 56548

RE: CCN: 245569
Cycle Start Date: May 13, 2026

Dear Administrator:

On May 13, 2026, the Minnesota Departments 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.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

6/26/2026

Administrator
Living Well Central
1555 CENTRAL AVENUE SOUTHWEST
CAMBRIDGE, MN 55008

RE: Event ID: UA4K-L2

Dear Administrator:

On June 22, 2026, the Minnesota Department of 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 with any questions related to this letter.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

