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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8I7X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00778

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245244**
2.STATE VENDOR OR MEDICAID NO.
(L2) **278525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH SYSTEM - LONG PRAIRIE**
(L4) **20 NINTH STREET SOUTHEAST**
(L5) **LONG PRAIRIE, MN** (L6) **56347**

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 **08/05/2021** (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)
12/31

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
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
	60			
(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 :
Christine Bodick-Nord HFE - NE II 09/16/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/22/2021 (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
11/01/1981
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 24, 2021

Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

RE: CCN: 245244
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 5, 2021, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

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 November 5, 2021 (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 February 5, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

(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 On August 2, 2021 through August 5, 2021, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On August 2, 2021 through August 5, 2021, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5244024C (MN75048), H5244025C (MN56473), H5244027C (MN52598), H5244028C (MN54664 and MN54774) and H5244029C (MN62373). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
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; §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	F 791		8/25/21

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F 791	Continued From page 2 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 ensure voiced dental concerns were addressed and acted upon for 1 of 1 resident (R22) reviewed for dental care. Findings include: R22's admission Minimum Data Set (MDS), dated 12/20/20, identified R22 had intact cognition and required supervision with personal hygiene tasks. The MDS further identified R22 had no natural teeth or tooth fragments. A Care Area Assessment (CAA) dated 12/20/20, indicated R22 had no natural teeth or tooth fragments. R22's Order Summary Report dated 7/9/21, indicated R22's physician ordered a dental consult for dentures on 7/13/21, and was signed off by a registered nurse (RN) on 7/13/21. A nurse progress note dated 7/13/21, revealed R22 inquired about a new set of dentures. A physician progress note dated 7/13/21, revealed edentulous referral to dentist.	F 791	F791-D Routine/Emergency Dental Services Facility allegedly failed to ensure voiced dental concerns were addressed and acted upon for 1 of 1 resident (R22) reviewed for dental care. Findings include: R22's admission Minimum Data Set (MDS) dated 12/20/20, identified R22 had intact cognition and required supervision with personal cares hygiene tasks. The MDS further identified R22had intact cognition and required supervision with personal cares hygiene tasks. The MDS further identified R22 had no natural teeth or tooth fragments. A Care Area Assessment (CAA) dated 12/20/20, indicated R22 had no natural teeth or tooth fragments. R22's Order Summary Reported dated 7/9/21, indicated R22's physician ordered a dental consult on 7/13/21, and was signed off by a RN on 7/13/21. A nurse progress noted dated 7/13/21, revealed R22 inquired about a new set of dentures. A Physician progress note date 7/13/21, revealed edentulous referral to dentist.	

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F 791	Continued From page 3 A Clinical Issues form dated 7/12/21 through 7/22/21, indicated R22 needed staff to look into a dental consult for R22. The Clinical Issues form lacked indication that staff had called for a dental consultation. During an interview on 8/2/21, at 2:36 p.m. R22 stated he tried to go to the dentist but had not gotten there yet. R22 stated he had requested from staff to go to the dentist however, had not heard back from the staff. During an interview on 8/5/21, at 8:47 a.m. with registered nurse (RN)-A revealed the appointment had not been checked off as completed. During an interview on 8/5/21 at 8:49 a.m. with RN-B stated there is an appointment to be done for R22 but we have not gotten it done yet. RN-B stated the appointment was not scheduled yet. A facility policy Dental Services-Long Term Care dated 1/2021, indicated oral health services are offered to meet the resident's needs and/or preferences. Facility personnel will assist the resident/family in making dental appointments and transportation arrangements as necessary.	F 791	A clinical issues form dated 7/12/21 through 7/22/21, indicated R22 needed staff to look into a dental consult for R22. The clinical issues form lacked indication that staff had called for a dental consultation. During an interview on 8/2/21, at 2:36pm. R22stated he tied to go to the dentist but had not gotten there yet. R22 stated he had requested from staff to go to the dentist, however had not heard back from the staff. During interview on 8/5/21, at 0847am, with RN-(A) revealed the appointment had not been checked off as completed. During interview on 8/5/21 at 0849 with RN (B) stated there is an appointment to be done for R22 but we have not gotten it done yet. RN (B) stated the appointment was not scheduled yet. A facility policy Dental Services-Long Term Care dated 1/2021, indicated oral health services are offered to meet the resident's needs and /or preferences. Facility personnel will assist the resident/family in making dental appointments and transportation arrangements as necessary. Providers' Plan of Correction- All staff are being reeducated on: Residents are encouraged to continue services with regular Dentist. If one is not available then offer Outreach Caring Hands Dental on days they are scheduled at the facility. For more detailed work arrangements will be made at the main office in Alexandria, MN. Resident Handbook that is provided on admission address lost or damaged	

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F 791	Continued From page 4	F 791	dentures and their rights. Facility policy Dental Services - Long Term Care addresses the loss or damaged dentures which is available for family and residents. Admission check list has been modified to highlight those assessments required on day of admission including Dental. Assessment Worksheet was modified for the Dental Assessment its completed not jus for the Admission, Annually, and significant change, but to be done quarterly to address with residents if a dental appointment is needed since the last review. Audit tool developed to monitor compliance for the next 90 days (quarterly) by the DON or designee. Education provided to staff related to documentation on resident preferences for dental providers. Documentation of appointments and any adjustments or cancelations made, by or for the residents. This includes the notification of the resident and or their family representative including transportation times. Audit Results to be reported to QAA Committee ensuring continued compliance. Completion Date: August 25th 2021.	
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that	F 800		8/25/21

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F 800	Continued From page 5 meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure all items on room trays were covered for 6 of 8 food trays observed on one cart during delivery of dinner to residents. This had the potential to affect 6 of 8 residents that received food trays from the cart. Findings include: On 8/2/21, at 5:31 p.m. dietary aide (DA)-A was preparing meal trays to be delivered to resident rooms. The main entree was scooped onto the plate by the dietary server, from the steam table, covered with a dome lid and handed to DA-A. The covered plates were placed on each tray with beverages and applesauce, and the trays were placed onto a metal four-shelved cart, with two trays on each shelf. DA-A then placed a white bath towel over the two trays on the first cart shelf. The remaining six trays were not covered when the metal cart was pushed out of the dining room and down the hallway, to deliver to resident rooms. There were no covers on the beverages, which included water, milk and juice, and there were no covers on the small bowls of applesauce. On 8/2/21, at 6:00 p.m. DA-A verified that the applesauce and beverages were not covered when the six trays were transported. DA-A stated that the Dietary Director (DD) and the Dietician (D) had been asked if the bottom three trays should have been covered. Additionally, DA-A stated, "we asked about the next shelves, and they told us no because the shelf above covered".	F 800	F800 Food and beverages will be covered or enclosed in a cart during transport. Education/training: Discussed regulatory 1. Huddles or 1:1 training - discuss rational. 2. Signage posted. 3. Procedure developed for distribution of trays' 4. Enclosed carts to be purchased for tray distribution - until carts arrive items will be covered during transport whether each item covered individual or with a cloth/towel. In situations where an enclosed cart is not used all food items will be covered with a cloth/towel. Ex: 1-4 trays. Monitoring: 1. Audits will be completed weekly x1 month for compliance with correction as indicated - if findings indicate lack of compliance' continue with weekly audits. 2. After moth 1 - audits will be completed bi-weekly. 3. On month 3 and beyond - random dining audits will be completed to check for compliance. Monitoring tool or options of ways to monitor: 1. CMS kitchen monitoring tool 2. Audit tool	

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F 800	Continued From page 6 On 8/4/21, at 12:51 p.m. DD acknowledged the beverages and applesauce on six trays of the four-shelved cart were not covered, stating, "that's the way it's being done, but we'll change that." The Food Storage policy, last approved 7/21, indicated "Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross-contamination."	F 800		

Electronically delivered
August 24, 2021

Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

Re: State Nursing Home Licensing Orders
Event ID: 8I7X11

Dear Administrator:

The above facility was surveyed on August 2, 2021 through August 5, 2021 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:

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00778	A. BUILDING: _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAI	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

(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	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On August 2, 2021 through August 5, 2021, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you

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2 000	Continued From page 1 have reviewed these orders, and identify the date when they will be completed. The following complaints were found to be UNSUBSTANTIATED: H5244024C (MN75048), H5244025C (MN56473), H5244027C (MN52598), H5244028C (MN54664 and MN54774), AND H5244029C (MN62373). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota 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	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. 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		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure voiced dental concerns were addressed and acted upon for 1 of 1 resident (R22) reviewed for dental care. Findings include: R22's admission Minimum Data Set (MDS), dated 12/20/20, identified R22 had intact cognition and required supervision with personal hygiene tasks. The MDS further identified R22 had no natural	21325	Corrected 8/24/21	8/24/21

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21325	Continued From page 3	21325		

teeth or tooth fragments.

A Care Area Assessment (CAA) dated 12/20/20, indicated R22 had no natural teeth or tooth fragments.

R22's Order Summary Report dated 7/9/21, indicated R22's physician ordered a dental consult for dentures on 7/13/21, and was signed off by a registered nurse (RN) on 7/13/21.

A nurse progress note dated 7/13/21, revealed R22 inquired about a new set of dentures.

A physician progress note dated 7/13/21, revealed edentulous referral to dentist.

A Clinical Issues form dated 7/12/21 through 7/22/21, indicated R22 needed staff to look into a dental consult for R22. The Clinical Issues form lacked indication that staff had called for a dental consultation.

During an interview on 8/2/21, at 2:36 p.m. R22 stated he tried to go to the dentist but had not gotten there yet. R22 stated he had requested from staff to go to the dentist however, had not heard back from the staff.

During an interview on 8/5/21, at 8:47 a.m. with registered nurse (RN)-A revealed the appointment had not been checked off as completed.

During an interview on 8/5/21 at 8:49 a.m. with RN-B stated there is an appointment to be done for R22 but we have not gotten it done yet. RN-B stated the appointment was not scheduled yet.

A facility policy Dental Services-Long Term Care

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21325	Continued From page 4 dated 1/2021, indicated oral health services are offered to meet the resident's needs and/or preferences. Facility personnel will assist the resident/family in making dental appointments and transportation arrangements as necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could audit all current residents to ensure dental service needs are being met. They could then in-service staff to ensure resident dental needs are being communicated to the appropriate person and dental needs are followed up on then audit oral care to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		8/24/21

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21426	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure administration of tuberculin skin test (TST) step one was completed within 72 hours of admission, or three months prior to admission, for 1 of 6 residents (R38) reviewed. Findings include: R38's admission record indicated R38 was admitted to the facility on 7/2/21, at 10:00 a.m. R38's Immunization Record indicated TST step one was administered on 7/6/21, at 3:30 p.m., four days after admission to the facility. During interview on 8/5/21, at 8:25 a.m. Assistant Director of Nursing (ADON) stated resident tuberculin (TB) screening for residents completed upon admission, and TST step one would be administered on the date of admission or the day after admission. Additionally, ADON confirmed R38 admitted on 7/2/21, and TST step one was administered on 7/6/21, at 3:30 p.m., stating, "I don't know why it wasn't done until 7/6". During interview on 8/5/21, at 10:16 a.m. Director of Nursing (DON) stated TB screening for residents would be completed within 72 hours of admission. Additionally, DON stated an evaluation would be completed upon admission, which included TB assessment questions, and	21426	Corrected - 8/24/21	

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21426	Continued From page 6 the assessment determined how further TB screening was completed. The facility Tuberculosis Infection Control Plan last revised 9/20, indicated two-step TST screening would be initiated within 72 hours of admission or within 90 days prior to admission. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and / or revise the facility system in place to ensure newly admitted residents receive screening of TB symptoms and the TST as required by state rule. Revise the system as needed and educate staff on the system in place. Monitor and review the delivery of the TST and adjust the system as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced	21915		8/18/21

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21915	Continued From page 7 by: Based on interview and record review, the facility failed to attempt to organize a family council at least one time annually. This had the potential to affect all 49 residents' families who resided in the facility. Findings include: Documentation revealed an attempt to hold a family council meeting on 2/25/2020 with zero members present. During an interview on 8/3/21, at 12:25 p.m. social services (SS) confirmed the last attempt to establish a family council was 2/25/2020. Further, there have been no attempts to use phone conferences or virtual meeting spaces to establish a family council nor had these options been communicated to families. A facility policy for Resident Rights Long Term Care, last revised 7/2021, stated designated staff were to work together to annually educate residents and family related to resident rights and any changes. SUGGESTED METHOD OF CORRECTION: The administrator or designee should ensure thorough attempts are made to develop a family council. The administrator or designee should develop monitoring systems to ensure thorough attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. .	21915	Corrected - 8/24/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST** **LONG PRAIRIE, MN 56347**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/10/2021. At the time of this survey, Centrcare Health System - Long Prairie 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. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2021

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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. Centracare Health System - Long Prairie was built in 1963 with additions in 1966 and 1976. The 1963 building is 1- story, without a basement, and was determined to be Type II (111) construction. In 1966 an addition to the south of the original building was built as a 1-story addition without a basement and was determined to be of Type II(111) construction. The 1976 addition to the east of the 1966 addition is 1-story with a partial basement and was determined to be of Type V (000) construction. The building is divided into	K 000		

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K 000	Continued From page 2 six smoke zones. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The facility has a capacity of 60 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		8/23/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 19.3.6.3.5. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/10/2021 at 11:06 AM, it was observed that the door to the soiled utility room labeled 1132 did not self-close and latch when tested. The Assistant Maintenance Manager verified this deficient condition at the time of discovery.	K 321	K321 Adjusted door closer and now the door self latches. Ron Klinkhammer - Maintenance Manger Provider's Plan of Correction Adjusted door closure and now self-latches Manager or designee will educate staff and conduct monthly Prevention Maintenance checks on all hazardous area doors (See Attachments) Audit Results to be reported to QAA Committee ensuring continued compliance (See Attachments)	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372		8/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST** **LONG PRAIRIE, MN 56347**

(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
K 372	Continued From page 4 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier construction per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3 and 8.5.6.2. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1) On 08/10/2021 at 09:16, it was observed that there was one penetration above the smoke barrier doors labeled 1838. 2) On 08/10/2021 at 09: 19, it was observed that there were two penetrations in the smoke barrier above smoke doors labeled 1845. The Assistant Maintenance Manager verified these deficient conditions at the times of discovery.	K 372	K372 Smoke Barrie Construction Ron Klinkhamer Maintenance Manger Provider's Plan of Correction Fire Cocked the penetrations to ensure smoke barrier construction per NFPS. Educate Cable Vendors via email to ensure future projects (See Attachment) Manager or designee will conduct an audit on future cable projects to ensure compliance quarterly (See Attachment) Audit Results to be reported to QAA Committee ensuring continued compliance (See Attachment)	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded	K 712		8/25/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST** **LONG PRAIRIE, MN 56347**

(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
K 712	Continued From page 5 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1) On 08/10/2021 at 09:57 AM, it was revealed that the fire drill sheet for the drill taking place on 06/23/2021 for the third shift did not indicate a time the drill took place. 2) On 08/10/2021 at 09:59 AM, it was revealed that the fire drill sheet for the drill taking place on 09/23/2020 for the third shift did not indicate a time the drill took place. 3) On 08/10/2021 at 10:03 AM, it was revealed that the fire drill sheet for the drill taking place on 12/23/2020 for the third shift did not indicate a time the drill took place. 4) On 08/10/2021 at 10:08 AM, it was revealed that three of the four 3rd shift drills took place on the 23rd day of the month. The Assistant Maintenance Manager verified these deficient conditions at the times of discovery.	K 712	K712 Fire Drills Ron Klinkhammer, Maintenance Manager Provider's Plan of Correction Added a line on the Fire Event Drill Report indicating time the drill took place and re-educated staff at huddle on update (See Attachment) Manager or designee will conduct audits by reviewing Fire Event Drill report after each event and documenting in huddle minutes monthly (See Attachment) Audit Results to reported to QAA Committee ensuring continued compliance (See Attachment)	