Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

Administrator
Central Health Care Center
444 North Cordova
Le Center, MN 56057

RE: CCN: 245401
Cycle Start Date: March 10, 2025

Dear Administrator:

On March 10, 2025, 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 June 10, 2025 (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 September 10, 2025 (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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
March 14, 2025

Administrator
Central Health Care Center
444 North Cordova
Le Center, MN 56057

Re: State Nursing Home Licensing Orders
Event ID: 8SHQ11

Dear Administrator:

The above facility was surveyed on March 9, 2025 through March 10, 2025 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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
	245401	A. BUILDING _____ B. WING _____	C 03/10/2025

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CENTRAL HEALTH CARE CENTER	444 NORTH CORDOVA LE CENTER, MN 56057

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E 000	Initial Comments On 3/9/25-3/10/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or	E 039		5/10/25

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

Electronically Signed | 03/21/2025

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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E 039	Continued From page 1 (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not	E 039		

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E 039	Continued From page 2 accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community	E 039		

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E 039	Continued From page 3 based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 4 (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional	E 039		

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E 039	Continued From page 5 exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 6 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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E 039	Continued From page 7 a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group	E 039		

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E 039	Continued From page 8 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated,	E 039		

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E 039	Continued From page 9 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a full-scale community-based exercise to test their emergency preparedness program (EPP) in response to an actual emergency event. This deficient practice had the potential to affect all residents residing in the facility, along with staff who work in the facility. Findings include: Review of the facilities EPP revised on 2/25/25, lacked a community-based exercise in the last year to test their EPP. During interview on 3/10/25 at 11:15 a.m., administrator stated he was unaware the facility needed to participate in a community-based exercise and he thought two table-top exercises would meet the requirements. Administrator further stated the facility had not participated in a community-based exercise. Facility policy titled Emergency Preparedness Plan reviewed 2/25/25, indicated educational training including drills and exercise are utilized to evaluate processes for emergency response in compliance with state and federal regulations.	E 039	The facility will immediately implement measures to comply with 42 CFR 483.73 (d) (2), which requires an annual community- based full-scale emergency drill. We have contacted the County Emergency Management Agency to schedule a full-scale community-based disaster exercise. The drill will be conducted no later than May 30th, 2025, to test our emergency Preparedness Plan (EPP). In the interim, the administrator, and emergency preparedness team have reviewed the recent actual emergency events and completed an after-action analysis, ensuring that any real event is properly documented and can count toward exercise requirements if applicable. All residents and staff will be included in the upcoming drill to ensure facility-wide preparedness. Staff Training: The administrator and all department heads (including the Maintenance Director and Nursing leadership) have been re-educated on CMS emergency exercise requirements, emphasizing that tabletop exercises do not replace the required annual full-scale/community drill. WE have	

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E 039	Continued From page 10	E 039	created staff read and sign for the IDT to review the EPP and the upcoming drill objectives. Moving forward, the Emergency Preparedness Coordinator (administrator or designee) will ensure all staff receive annual training on heir roles during emergency exercises. Staff will also be oriented on any updates to emergency procedures learned from the scheduled drill (for example, evacuation routes, communication protocols), and new hires will receive emergency preparedness training upon orientation. Policy Updates: The facility's Emergency Preparedness plan policy will be updated to clearly reflect the annual full-scale exercise requirement and the need for an additional exercise on alternate years (e.g. a tabletop drill) per federal regulations. The revised policy will detail the process for coordinating community-based exercises, including maintaining documentation of all drills and real emergencies and analyzing the outcomes. We will incorporate a checklist into the policy to track scheduled exercises, responsible personnel and follow-up actions. The policy will also specify that if an actual emergency occurs (e.g. natural disaster requiring EPP activation), the facility will document ongoing compliance with CMS emergency Preparedness testing requirements and prevents the oversight that occurred. Facility Modifications: No structural modifications are needed to correct this deficiency. However, we have invested in	

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E 039	Continued From page 11	E 039	improved emergency drill supplies and coordination tools. For example, we assembled emergency drill kits (including vests, mock resident tracking forms and communication devices). We have also established a designated command center area in the facility for use during drills or real events. These preparations will support a successful full-scale exercise but do not involve construction or physical plant changes. The natue of this deficiency was procedural (a missed drill), so the corrections are focuse on process and training rather than physical modifications. Timeline for completion: May 30, 2025 - The full scale community integrated emergency exercise will be completed by this date (or sooner if community partners are available earlier). All policy revisions and staff trainings will be completed by April 15, 2025, well in advance of the drill. Ongoing compliance will be monitored through the Quality Assurance Committee: the Administrator will report quarterly on emergency drill scheduling and outcomes. Substantial compliance with E039 will be achieved by the completion of the community-based drill and verification by our QA committee that all required elements of the emergency preparedness program are in place.	
F 000	INITIAL COMMENTS On 3/9/25-3/10/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility	F 000		

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F 000	Continued From page 12 was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54019302C (MN00102975). 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		3/31/25

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F 585	Continued From page 13 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and	F 585		

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F 585	Continued From page 14 coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their grievance process for	F 585	Corrective action plan: resident R11's grievance regarding a missing jean jacket	

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F 585	Continued From page 15 missing personal property for 1 of 1 resident (R1) who reported a missing item. Findings include: R11's admission Minimum Data Set (MDS) assessment dated 12/23/24, indicated R11 was cognitively intact, no behaviors, very important to choose what clothes to wear, dependent on staff for dressing and diagnoses included after care following joint replacement surgery. On 3/9/25 at 11:22 a.m., R11 stated she had a jean jacket that was missing. R11 stated the jacket was put in the laundry and never returned. R11 stated she informed multiple staff about the missing jean jacket and had not heard back about the missing jacket. R11 stated the missing jacket was at least thirty dollars. On 3/10/25 at 7:26 a.m., social services (SS)-A stated R11 reported a missing jean jacket over two weeks ago and she helped search R11's room and other staff looked throughout the facility for the jacket. SS-A stated she looked in laundry and other resident rooms for the jacket and the jacket was not found. SS-A stated a form was filled out regarding the missing jacket. SS-A was observed to look for the paper form in her office and confirmed she could not find the form. SS-A stated she had seen R11 wear the jean jacket prior to her reporting the jacket missing. SS-A stated the process for missing items was a form was filled out, the missing item was discussed in IDT (interdisciplinary team) meeting, and the administrator was made aware. SS-A confirmed the IDT team and administrator was not made aware as expected, and follow up wit R11 had not occurred.	F 585	has been resolved. Social services interviewed R11 on 03/10/2025 and initiated a formal grievance report that same day, per our grievance policy. A thorough search of the laundry, resident room, and lost and found was conducted for the missing jacket. To identify any other residents affected, the Social Services Director audited the past 60 days of complaints and inquired on 3/11/25 with residents and families about any unreported missing belongings. No other outstanding missing-item issues were identified, indicating R11's case was an isolated incident.. Nonetheless, for prevention, any resident reporting lost items going forward will have their concern logged immediately as a grievance and investigated within 5 days. The facility will ensure tiemly resolution and communication for each such grievance. Staff Training: All staff have been re-educated on the grievance process for missing property to ensure prompts reporting and response. Staff to receive education focused on resident rights and grievances, using R11's case as an example. Nursing assistants, laundry personnel, and housekeepers were specifically instructed to immediately report any resident complaints of lost or missing items to the charge nurse or social services. The grievance official (Administrator) reviewed with department heads the proper procedure: acknowledge the grievance in writing, investigate the issue and provide a written outcome to	

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F 585	Continued From page 16 On 3/10/25 at 7:31 a.m., laundry (L)-C stated she had been aware of R11's missing jacket about a month ago but had not been able to locate the jacket. L-C indicated social services follows up with the residents. On 3/10/25 at 10:28 a.m., the administrator stated social services was expected to follow the policy regarding missing clothing and make him aware when a resident reported a missing item. The administrator confirmed he was not made aware of R11's report of the missing jacket. The administrator confirmed the missing item process was not followed through. Facility Missing Item Policy and Procedure dated 3/1/21, indicated Social service department will complete a missing item report Social service department will begin an investigation to locate the missing items and will inform the IDT at the following morning meeting of the missing item report. If the item is unable to be located, social services will discuss with the administrator possible alternatives to replace the missing item. Social services will notify the residents representative of the missing item if its unable to be located immediately with the 5-day investigation person. Social services will office possible alternative to replace the missing item. The facility administrator will sign off of the report once the investigation is finalized, the report will be filed in the residents soft file in the social service office.	F 585	the resident within a reasonable timeframe (no later than 7 days, per facility policy). We emphasized to staff that missing personal belongings must be treated with the same urgency as any other grievance, to meet regulatory requirements for prompt resolution and documentation. Going forward, grievance procedure training will be included in new employee orientation and annual staff training to reinforce these expectations. Policy Updates: The facility's grievance policy (resident's rights section) was reviewed and revised on 3/19/25 (and again on 3/26/25) to strengthen provisions for handling missing personal property. The updated policy explicitly lists "loss of personal items" as a grievable concern and outlines a specific protocol: staff must assist the resident in filing a written grievance form immediately, Social services/administration will initiate an investigation within 24 business hours, and a written decision will be provided to the resident or representative within 5 business days of the complaint. The policy now includes a template "Missing property investigation form," which documents search efforts, interviews with staff and final resolution. If our investigation determines that the facility was at fault, beyond a reasonable doubt, the facility will accept responsibility for the lost/missing item(s) and will replace item(s) or provide monetary compensation equal to items estimated value. We also added a requirement to maintain a log of all personal property grievances and their	

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F 585	Continued From page 17	F 585	outcomes for at least 3 years, in line with federal regulations. This log will be reviewed monthly in QA meetings to ensure proper follow-up. These revisions ensure our grievance process is comprehensive and compliant, and they address the lapse in following the process that led to this deficiency. Facility Modifications: While no structural changes are required, we have made some administrative and process enhancements. The laundry department has implemented a resident clothing labeling audit, verifying that all garments are tagged with the resident's name to reduce loss. We designated a specific "lost and found location" in the facility where any unidentified clothing or items will be stored and logged, with regular checks by Social Services. Additionally, we installed a communication board in the laundry area where staff can note any found items or missing-item inquiries. Social services will also be placing a missing item log at the nurse desk to communicate to staff items missing in the facility and a copy of the initial missing item report will be sent to all department heads via email. These measures are process improvements to help prevent lost belongings and quickly reunite found items with owners; they support the plan of correction by reducing the chance of recurrence. Timeline for Completion: March 31, 2025 all corrective actions will be fully implemented by this date. R11's issue	

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F 585	Continued From page 18	F 585	was resolved 03/27/25 by issuing a monetary amount for estimated value of jacket which resident was agreeable to this resolution and staff training and policy revisions were completed by 3/19/25. The new procedures (label audits, lost and found log) began immediately on 3/20/25. The facility Administrator or designee will monitor compliance by reviewing the grievance log weekly for the next 3 months to ensure any new missing property complaints are handled per policy. We expect to achieve full compliance with F585 by the end of March 2025, with ongoing monitoring through June 2025 to validate sustained compliance.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure safe and appropriate water temperatures were maintained below 120 degrees Fahrenheit (F) to prevent potential scalding for 5 of 8 residents (R8, R20, R24, R11, R25) observed for accidents and hazards.	F 689	Corrective Action Plan: The facility took immediate action to eliminate the hazard of excessively hot water temperatures exceeding 120 degrees fahrenheit identified during the survey. On March 9, 2025 the Maintenance Director promptly adjusted the hot water heater thermostats and inspected the mixing valves that	3/31/25

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F 689	Continued From page 19 Findings include: R8's facesheet printed on 3/11/25, included diagnoses of congestive heart failure (the heart doesn't pump blood as well as it should), dementia and schizophrenia (prevents a person's ability to think, feel and behave clearly). R8's quarterly Minimum Data Set (MDS) assessment dated 12/30/24, indicated R8 had severe cognitive impairment, he was understood and could usually understand. R8 required supervision with toileting. R8's care plan dated 6/23/23, indicated staff would assist with transfers/ambulation, but R8 would get up on his own with walker. R20's facesheet printed on 3/11/25, included diagnosis of chronic kidney disease. R20's quarterly MDS assessment dated 1/29/25, indicated R20 was cognitively intact, was understood and could understand. R20 was independent with toileting. R20's care plan dated 8/7/23, indicated R20 could ambulate around his environment independently using assist of wheelchair. R24's facesheet printed on 3/11/25, included diagnosis of congestive heart failure. R24's significant change MDS dated 11/29/24, indicated R24 was cognitively intact, could understand and be understood and was independent with toileting. R24's care plan dated 10/14/24, indicated	F 689	regulate water temperature on each unit. Hot water temperatures were then re-measured in resident sinks and showers across all units. These measurements of water temperatures included measurements taken from resident rooms R8, R20, R24, R11 and R25. All readings were brought into a safe range (105-115 degrees fahrenheit). Staff Training: Staff have been educated on preventing scald injuries and monitoring water safety. Staff will receive education on checking water temperatures before assisting residents with bathing or using faucet. Staff will be educated that if water feels too hot to touch, they must immediately stop using it and report it to maintenance or the charge nurse. Nursing staff will verify safe water temperature with a thermometer prior to residents' showers, especially for dependent residents. Maintenance personnel received additional training on proper hot water system maintenance, including the importance of maintaining temperatures in a safe range of 105-115 degrees Fahrenheit. Policy Updates: The facility has updated it's Hot Water Temperature Control Policy. The revised policy specifies that resident-use hot water will be maintained between 105 and 115 degrees Fahrenheit, in accordance with safety guidelines to prevent scalding. It details the procedure for daily monitoring of water temperatures: maintenance staff will log water temperatures from several designated	

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F 689	Continued From page 20 transfer independence with 4-wheeled walker. R11's facesheet printed on 3/11/25, included diagnoses of arthritis and aftercare following joint replacement surgery. R11's admission MDS assessment dated 12/23/24, indicated R11 was cognitively intact, could understand and be understood and was dependent upon staff for assistance to the toilet. R11's care plan dated 12/30/24, indicated R11 had an ADL (activity of daily living) deficient related to recent surgery and required assistance of staff to toilet. R25's facesheet printed on 3/11/25, included diagnoses of spinal stenosis (spaces inside the bones of the spine get too small) and spondylosis with myelopathy (spinal cord become depressed). R25's admission MDS assessment dated 2/11/25, indicated R25 was cognitively intact, could understand and be understood; and was independently with toileting. R25's care plan dated 2/6/25, indicated toileting independence. During an observation on 3/10/25 at 11:35 a.m., the hot water coming out of the faucet in R2's bathroom sink felt unusually hot. During an observation and interview on 3/10/25 at 11:47 a.m., maintenance director (MD)-A used an instant read thermometer to measure the temperature of the water from R2's bathroom faucet. The temperature measured 120 degrees F. MD-A who was new to the role since August	F 689	locations (resident room taps and shower rooms in each wing) each day. If any reading exceeds 115 degrees, the policy mandates an immediate corrective action (such as adjusting the mixing valve or heater setting) and a re-check within 1 hour. We also incorporated into the policy the requirement to document any out of range temperature as an incident and to notify the Administrator and Director of Nursing. The QA committee will review the weekly aggregate of water temp logs at its meetings. Facility Modifications: To permanently resolve we have checked the showers in the bathrooms to ensure anti-scald devices were on shower heads and a thermostatic valve on the whirlpool. All hot water tanks have been set to an appropriate level and labeled with warning signage to prevent unauthorized temperature increases. The facility found between updating monitoring frequency and ensuring compliance no further building modifications were needed. Timeline: All immediate corrective actions were completed by 3/18/25. Staff education and policy revisions to be completed by 3/31/25. The ongoing monitoring of water temperatures began on 3/11/25 and will continue indefinitly as part of routine operations.	

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F 689	Continued From page 21 2024, stated he was unaware of safe, maximum water temperature for resident rooms. During record review, documents provided by MD-A titled Monthly Water Temperature Checks, indicated water temperature was checked monthly in two resident bathrooms faucets on each of the three wings. Results included temperatures over 120 degrees F with no action taken. The form did not identify safe parameters for water temperature. For May and June 2024, all 12 temperatures were recorded as being 109 degrees F, except for one room which was 108 degrees F. Starting in August 2024, the recorded temperatures were significantly higher: --8/20/24, of the six readings, two were > 120 degrees F: 122.3 F and 120.8 F. --9/13/24, of the six readings, two were > 120 degrees F: 120.4 F and 121.9 F. --10/30/24, of the six readings, three were > 120 degrees F: 120.4 F and 121.7 F x 2. --11/26/24, of the six readings, none were > 120 degrees F. --12/5/24, of the six readings, four were >120 degrees F: 120.8 F, 122.5 F, 123.3 F, 121.6 F. --1/7/25, of the six readings, four were >120 degrees F: 120.6 F, 121.4 F, 121.2 F, 121.6 F. --2/7/25, of the six readings, two were > 120 degrees F: 122.3 F, 121.1 F. --Undated (for March 2025), of the six readings, four were > 120 degrees F: 121.6 F, 122.7 F, 120.6 F, 123.6 F. During an interview on 3/10/25 at 1:38 p.m., nursing assistant (NA)-B identified eight residents: R8, R20, R16, R24, R11, R25, R3,	F 689		

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F 689	Continued From page 22 R21, who were able to toilet independently and/or who used the sink in their bathrooms. During observation and interview on 3/10/25, from 1:45 p.m. to 2:03 p.m., along with MD-A, went to each of the eight rooms and temped the hot water at the bathroom sink faucet. Results indicated five of eight faucets had water temperatures exceeding 120 degrees F: 1. R8: 122 degrees F 2. R20: 122.3 degrees F 3. R24: 121.8 degrees F 4. R11: 122.5 degrees F 5. R25: 121.6 degrees F; R25 stated the water did not feel too warm to him. During an interview on 3/10/25 at 1:50 p.m., NA-A was not aware of hot water complaints from residents nor was she aware of any resident being scaled from hot water. During an interview on 3/10/25 at 2:06 p.m., the director of nursing (DON) stated no residents had reported nor were observed being scalded by hot water. During an interview on 3/10/25 at 2:45 p.m., the administrator was informed water temperatures in some resident bathrooms exceeded 120 degrees F. The administrator stated he would work with MD-A to correct it. A policy on maintaining and monitoring water temperature from resident bathroom sink faucets was requested and not received.	F 689		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		3/31/25

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F 812	Continued From page 23 §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 discard food that had expired and ensure all foods were labeled and dated with opened and discard dates. This had the potential to affect all residents residing in the facility who were served food from the kitchen. Findings include: During observation on 3/9/25 at 10:30 a.m., 16 single serve red gelatin in small plastic condiment-style containers with lids and hand written dates of 2/27/25, 23 single serve applesauce in small plastic condiment-style containers with lids with handwritten dates of 2/28/25, and one open medium plastic container of turkey with a hand written date of 3/2/25, were in the main kitchen Tonka refrigerator.	F 812	All identified expired or improperly dated food items were immediately discarded to eliminate any potential risk of foodborne illness. ON 3/9/25, when the surveyor noted single-serve gelatin and applesauce containers dated late February and an open turkey container dated 3.2.25 in the refrigerator, the Dietary Manager promptly removed and discarded those items on the spot. That same day, the Dietary Manager and kitchen staff conducted top to bottom inspection of all refrigerators, freezers and dry storage areas in the kitchen. They disposed of any expired products and labeled any undated items with the correct open/date marks. The issue was considered to be systemic (affecting the kitchen inventory) but no	

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F 812	Continued From page 24 During observation on 3/9/25 at 4:50 p.m., single serve containers of applesauce dated 2/28/25, were observed on the top of each cart. During interview on 3/9/25 at 4:55 p.m., licensed practical nurse (LPN)-A stated the applesauce was used for residents who had crushed medications and preferred them mixed with something. LPN-A was unsure what the date on the container indicated or how long the applesauce was good for. During interview on 3/10/25 at 10:03 a.m., dietary manager (DM)-D stated the dates on the containers indicated the date they were put in the refrigerator and they should be used within five days. DM-D further stated the gelatin should have been discarded on 3/4/25, the applesauce discarded on 3/5/25, and the turkey discarded on 3/7/25. DM-D stated the applesauce was used multiple times daily for snacks for residents and by the nurses for crushed medications. DM-D was unsure what the gelatin and turkey had been used for or when it was last used. DM-D stated food opened in the refrigerator should be discarded within five days for food safety reasons and to prevent foodborne illnesses. During interview on 3/10/25 at 12:46 p.m., administrator stated he was unaware of foods that should have been discarded from the refrigerator but expected the dietary staff to label and discard foods within their expected timeframe to ensure resident safety. A facility document titled Refrigerator Procedure dated 12/24, indicated perishable open items may not be in fridge longer than three days after	F 812	residents showed signs of illness, and all potentially unsafe food was removed proactively. To protect all residents going forward, the facility has also obtained fresh stock to replace discarded food as needed, ensuring continuous meal service with safe items. Staff Training: The dietary manager provided re-education to all dietary staff regarding proper food storage, labeling and rotation. In this training, staff were taught to follow "first in, first out" principles and date-mark all food containers when opened. We emphasized that perishable and prepared foods must be labeled with the open date and a discard date. The training also covered checking for expiration dates daily during kitchen closing procedures. Policy Updates: The food storage and labeling policy was reviewed and revised to address the deficiencies. The updated policy mandates that all foods (refrigerated, frozen or dry storage) must be labeled with the date received or opened and the date by which it should be used or discarded, in line with food safety guidelines. We added explicit guidelines for discarding expired items: any food item must be discarded by its expiration date or, if undated and past a reasonable storage time, immediately. The policy now includes a daily "walk-through" log for the kitchen. It also outlines a weekly audit every Monday, where the Dietary Manager or designee will inspect all storage areas for compliance with labeling	

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F 812	Continued From page 25 placed in the fridge. Items will be tossed if in the fridge after three days. Facility Policy and Procedure on Refrigerator Storage dated 10/15/24, indicated any leftover food would be put in the fridge in clean containers with tight fitting lids. Each container will be labeled and dated and will have the use by date. Any food not used by the use by date will be disposed of immediately. All food and nutritional staff are responsible for this.	F 812	and remove any items approaching expiration. Facility Modifications: No major facility renovations were required; however, we have made some improvements in kitchen organization and equipment to support proper food storage. We purchased additional air-tight storage containers and labels to ensure all foods, especially those decanted from orignial packaging, can be sealed and labeled properly. A new labeling system was introduced: neon color coded day label stickers are now used for labeling and dating with expiration date. Then a red sticker will be put on each container that will be notifying staff that the following day is the expiration date, so that staff can easily identify how long an item has been in use at a glance. These enhancements, while not structural changes, modify the facility's food storage setup to make compliance easier and more foolproof. They complement the policy and training steps by adding practical tools to maintain food safety. Timeline for completion: All aspects of this plan of correction will be in place by 3/31/25. Immediate actions (discarding expired foods) were completed on 3/9/25.	
F 880 SS=F	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	F 880		4/15/25

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F 880	Continued From page 26 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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, 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	F 880		

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F 880	Continued From page 27 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a documented water management program including an assessment with a description of the building water system using text and flow diagrams to identify where Legionella and other opportunistic waterborne pathogens could grow and spread. Furthermore, the facility failed to implement measures to prevent the growth of opportunistic waterborne pathogens. This had the potential to affect all residents and staff using water in the facility. Findings include: During interview on 3/10/25 at 11:29 a.m.,	F 880	F880- Infection Prevention & Control (Water Management Program) Corrective Action: The facility has developed and is implementing a comprehensive Water Management Program to address the lack of a documented plan for managing our building's water system. The purpose of this program is to mitigate the risks of Legionella and other waterborne pathogens. On March 11, 2025, we convened a newly formed Water Management Team consisting of the Maintenance Direct, the	

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F 880	Continued From page 28 maintenance director (MD)-A stated he did not know what Legionella was and was not aware of what he was supposed to do for water management. MD-A stated he did not have a water management program and did not have an assessment or text and flow diagram to identify how water traveled throughout the facility. MD-A stated he started his position in August 2024 and had not had any training on water management. During interview on 3/10/24 at 12:45 p.m., registered nurse (RN)-A also known as the infection preventionist, stated she oversaw infection prevention and control at the facility, was aware of what Legionella was, but that the maintenance director was supposed to take care of the water management program at the facility. RN-A stated they had not had any Legionella-related pneumonia infections. During interview on 3/10/24 at 12:32 p.m., administrator stated he was unable to find a water management program or an assessment of the buildings water system. Administrator further stated MD-A was new and may need education on water management. Facility Infection Prevention and Control program policy dated 1/6/25, indicated: 16: Water management a) A water management program has been established as part of the overall infection prevention and control program. b) Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c) The Maintenance Director serves as the leader of the water management program.	F 880	Infection Preventionist, the Administrator, the Medical Director (or designee), and the Director of Environmental Services. This team conducted a full assessment of the building's water system, mapping out the water flow and endpoints (hot water heaters, storage tanks, pipes, faucets, showerheads, etc.)- effectively creating the text and flow diagram that was previously missing. Areas where Legionella or other opportunistic bacteria could potentially grow (e.g., the hot water tank, infrequently used outlets, shower heads with aerators) were identified. Based on this risk assessment, we have implemented control measures immediately and began a routine flushing schedule where all low-use water outlets are flushed at least weekly. We also cleaned and disinfected all shower heads and sink aerators on 03/12/25 to remove any potential biofilm. On February 18th, 2025 the facility collected water samples to test for Legionella bacteria- the results were found to be within control measures; however, if any future tests were to result in higher levels, we have arrangements for immediate logs to document these activities. By taking these steps, we have addressed the critical absence of a water management plan: the facility now actively inhibits microbial growth in the water system, reducing the risk of Legionnaires' disease for all residents and staff (QSO17-30-18). Staff Training: Our Maintenance Director, Infection Preventionist, and broader staff are being	

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F 880	Continued From page 29 The water management program and policy were requested but not received.	F 880	trained on the water management protocols. This training will cover what Legionella is, why a water management plan in important, each component of our specific program and each member's role in our Water Management Program. The Maintenance Director, who was previously unaware of these requirements, is now well-informed and has been designated as the leader of the incorporated waterborne pathogen surveillance into the Infection Control Committee agenda. Going forward, the facility will include water management training in orientation for new maintenance personnel and will provide annual refresher training for the Water Management Team to review and update the program. Policy Updates: The facility has established a written Water Management Program Policy, effective 03/22/25, as an extension of our Infection Prevention and Control Program. This new policy formalizes the practices we've put in place: it describes the composition of the Water Management Team, the requirement for a complete water system diagram and risk assessment, and the control measures and monitoring protocols adopted. Key elements of the policy include: maintaining hot water storage and cold water storage within control measures, regular flushing of low-use water outlets (with a schedule listing locations and frequency), monthly temperature checks at distal outlets, and periodic testing for water quality (to include testing for Legionella annually, or	

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F 880	Continued From page 30	F 880	immediately if there is a possible waterborne illness). The policy also specifies actions to take if control limits are not met- for example, if water tests show Legionella, the policy directs immediate disinfection procedures and notification of public health authorities. We integrated guidance from CMS QSO 17-30 and the CDC Toolkit into our policy, aligning with the expectation that facilities have policies to inhibit microbial growth in water systems (QSO17-30-18). Furthermore, the Infection Control Committee charter has been updated to include oversight of the water management program, ensuring that this issue is reviewed at least annually (483.80(f) annual IPC program review will encompass water management). The new policy was approved by the Administator amd Medical Director and has been communicated to all relevant staff. With this robust policy in place, the facility's practices are now in full compliance with F880 Infection Control standards regarding water management. Timeline for Completion: April 15, 2025- The Water Management Program will be fully implemented by this date. Many actions have already occurred: initial risk assessment and system mapping were done by 03/15/25, immediate control measures (flushing, temperature adjustments, fixture cleaning) were initiated by 03/12/25, and additional staff training will be held in April. The formal written policy and program document will be finalized and	

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F 880	Continued From page 31	F 880	disseminated by the first week of April 2025. Any additional facility modifications (such as more permanent secondary disinfection systems) identified as necessary will be completed by 04/15/25. The facility considers itself on track to achieve compliance with F880 once the policy is in effect and at lease one cycle of monitoring is completed and reviewed by the Infection Control Committee in April. To ensure ongoing compliance, the Administrator will include the water management program in the Quality Assurance Performance Improvement (QAPI) review. The QA committee will review water monitoring logs and any testing results monthly for the next 6 months. By April 15, we will have addressed the deficiency fully, with documentation available to demonstrate a functioning water management program that meets regulatory standards (QSO17-30-18). Central Health Care will thus be in substantial compliance with all aspects of F880 and will continuously uphold these practices to protect our residents.	

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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: On 3/9/25-3/10/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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	00800	A. BUILDING: _____ B. WING _____	C 03/10/2025

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54019302C (MN00102975). NO citations were issued. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> 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 Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 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		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to discard food that had expired and ensure all foods were labeled and dated with opened and discard dates. This had the potential to affect all residents residing in the facility who were served food from the kitchen. Findings include: During observation on 3/9/25 at 10:30 a.m., 16 single serve red gelatin in small plastic condiment-style containers with lids and hand written dates of 2/27/25, 23 single serve applesauce in small plastic condiment-style containers with lids with handwritten dates of 2/28/25, and one open medium plastic container of turkey with a hand written date of 3/2/25, were in the main kitchen Tonka refrigerator. During observation on 3/9/25 at 4:50 p.m., single	21100	Corrected.	3/31/25

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21100	Continued From page 3 serve containers of applesauce dated 2/28/25, were observed on the top of each cart. During interview on 3/9/25 at 4:55 p.m., licensed practical nurse (LPN)-A stated the applesauce was used for residents who had crushed medications and preferred them mixed with something. LPN-A was unsure what the date on the container indicated or how long the applesauce was good for. During interview on 3/10/25 at 10:03 a.m., dietary manager (DM)-D stated the dates on the containers indicated the date they were put in the refrigerator and they should be used within five days. DM-D further stated the gelatin should have been discarded on 3/4/25, the applesauce discarded on 3/5/25, and the turkey discarded on 3/7/25. DM-D stated the applesauce was used multiple times daily for snacks for residents and by the nurses for crushed medications. DM-D was unsure what the gelatin and turkey had been used for or when it was last used. DM-D stated food opened in the refrigerator should be discarded within five days for food safety reasons and to prevent foodborne illnesses. During interview on 3/10/25 at 12:46 p.m., administrator stated he was unaware of foods that should have been discarded from the refrigerator but expected the dietary staff to label and discard foods within their expected timeframe to ensure resident safety. A facility document titled Refrigerator Procedure dated 12/24, indicated perishable open items may not be in fridge longer than three days after placed in the fridge. Items will be tossed if in the fridge after three days.	21100		

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21100	Continued From page 4 Facility Policy and Procedure on Refrigerator Storage dated 10/15/24, indicated any leftover food would be put in the fridge in clean containers with tight fitting lids. Each container will be labeled and dated and will have the use by date. Any food not used by the use by date will be disposed of immediately. All food and nutritional staff are responsible for this. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or designee, could educates staff to ensure appropriate storage of perishable food items is maintained in the kitchen. The dietary manager, registered dietician, or designee could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) committee for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an	21390		4/15/25

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21390	Continued From page 5 immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have a documented water management program including an assessment with a description of the building water system using text and flow diagrams to identify where Legionella and other opportunistic waterborne pathogens could grow and spread. Furthermore, the facility failed to implement measures to prevent the growth of opportunistic waterborne pathogens. This had the potential to affect all residents and staff using water in the facility. Findings include: During interview on 3/10/25 at 11:29 a.m., maintenance director (MD)-A stated he did not know what Legionella was and was not aware of what he was supposed to do for water management. MD-A stated he did not have a water management program and did not have an assessment or text and flow diagram to identify	21390	Corrected.	

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21390	Continued From page 6 how water traveled throughout the facility. MD-A stated he started his position in August 2024 and had not had any training on water management. During interview on 3/10/24 at 12:45 p.m., registered nurse (RN)-A also known as the infection preventionist, stated she oversaw infection prevention and control at the facility, was aware of what Legionella was, but that the maintenance director was supposed to take care of the water management program at the facility. RN-A stated they had not had any Legionella-related pneumonia infections. During interview on 3/10/24 at 12:32 p.m., administrator stated he was unable to find a water management program or an assessment of the buildings water system. Administrator further stated MD-A was new and may need education on water management. Facility Infection Prevention and Control program policy dated 1/6/25, indicated: 16: Water management a) A water management program has been established as part of the overall infection prevention and control program. b) Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c) The Maintenance Director serves as the leader of the water management program. The water management program and policy were requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee, could develop and implement policies and procedures related to Legionnaires' disease	21390		

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21390	Continued From page 7 and ensure the facility develops a water management program. The administrator, DON or designee could educate staff on the policies and the Quality Assurance Performance Improvement (QAPI) committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure safe and appropriate water temperatures were maintained below 120 degrees Fahrenheit (F) to prevent potential scalding for 5 of 8 residents (R8, R20, R24, R11, R25) observed for accidents and hazards. Findings include: R8's facesheet printed on 3/11/25, included diagnoses of congestive heart failure (the heart doesn't pump blood as well as it should), dementia and schizophrenia (prevents a person's ability to think, feel and behave clearly). R8's quarterly Minimum Data Set (MDS) assessment dated 12/30/24, indicated R8 had	21710	Corrected.	3/31/25

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21710	Continued From page 8 severe cognitive impairment, he was understood and could usually understand. R8 required supervision with toileting. R8's care plan dated 6/23/23, indicated staff would assist with transfers/ambulation, but R8 would get up on his own with walker. R20's facesheet printed on 3/11/25, included diagnosis of chronic kidney disease. R20's quarterly MDS assessment dated 1/29/25, indicated R20 was cognitively intact, was understood and could understand. R20 was independent with toileting. R20's care plan dated 8/7/23, indicated R20 could ambulate around his environment independently using assist of wheelchair. R24's facesheet printed on 3/11/25, included diagnosis of congestive heart failure. R24's significant change MDS dated 11/29/24, indicated R24 was cognitively intact, could understand and be understood and was independent with toileting. R24's care plan dated 10/14/24, indicated transfer independence with 4-wheeled walker. R11's facesheet printed on 3/11/25, included diagnoses of arthritis and aftercare following joint replacement surgery. R11's admission MDS assessment dated 12/23/24, indicated R11 was cognitively intact, could understand and be understood and was dependent upon staff for assistance to the toilet.	21710		

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21710	Continued From page 9 R11's care plan dated 12/30/24, indicated R11 had an ADL (activity of daily living) deficient related to recent surgery and required assistance of staff to toilet. R25's facesheet printed on 3/11/25, included diagnoses of spinal stenosis (spaces inside the bones of the spine get too small) and spondylosis with myelopathy (spinal cord become depressed). R25's admission MDS assessment dated 2/11/25, indicated R25 was cognitively intact, could understand and be understood; and was independently with toileting. R25's care plan dated 2/6/25, indicated toileting independence. During an observation on 3/10/25 at 11:35 a.m., the hot water coming out of the faucet in R2's bathroom sink felt unusually hot. During an observation and interview on 3/10/25 at 11:47 a.m., maintenance director (MD)-A used an instant read thermometer to measure the temperature of the water from R2's bathroom faucet. The temperature measured 120 degrees F. MD-A who was new to the role since August 2024, stated he was unaware of safe, maximum water temperature for resident rooms. During record review, documents provided by MD-A titled Monthly Water Temperature Checks, indicated water temperature was checked monthly in two resident bathrooms faucets on each of the three wings. Results included temperatures over 120 degrees F with no action taken. The form did not identify safe parameters for water temperature.	21710		

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21710	Continued From page 10 For May and June 2024, all 12 temperatures were recorded as being 109 degrees F, except for one room which was 108 degrees F. Starting in August 2024, the recorded temperatures were significantly higher: --8/20/24, of the six readings, two were > 120 degrees F: 122.3 F and 120.8 F. --9/13/24, of the six readings, two were > 120 degrees F: 120.4 F and 121.9 F. --10/30/24, of the six readings, three were > 120 degrees F: 120.4 F and 121.7 F x 2. --11/26/24, of the six readings, none were > 120 degrees F. --12/5/24, of the six readings, four were >120 degrees F: 120.8 F, 122.5 F, 123.3 F, 121.6 F. --1/7/25, of the six readings, four were >120 degrees F: 120.6 F, 121.4 F, 121.2 F, 121.6 F. --2/7/25, of the six readings, two were > 120 degrees F: 122.3 F, 121.1 F. --Undated (for March 2025), of the six readings, four were > 120 degrees F: 121.6 F, 122.7 F, 120.6 F, 123.6 F. During an interview on 3/10/25 at 1:38 p.m., nursing assistant (NA)-B identified eight residents: R8, R20, R16, R24, R11, R25, R3, R21, who were able to toilet independently and/or who used the sink in their bathrooms. During observation and interview on 3/10/25, from 1:45 p.m. to 2:03 p.m., along with MD-A, went to each of the eight rooms and temped the hot water at the bathroom sink faucet. Results indicated five of eight faucets had water temperatures exceeding 120 degrees F: 1. R8: 122 degrees F 2. R20: 122.3 degrees F 3. R24: 121.8 degrees F 4. R11: 122.5 degrees F	21710		

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21710	Continued From page 11 5. R25: 121.6 degrees F; R25 stated the water did not feel too warm to him. During an interview on 3/10/25 at 1:50 p.m., NA-A was not aware of hot water complaints from residents nor was she aware of any resident being scaled from hot water. During an interview on 3/10/25 at 2:06 p.m., the director of nursing (DON) stated no residents had reported nor were observed being scalded by hot water. During an interview on 3/10/25 at 2:45 p.m., the administrator was informed water temperatures in some resident bathrooms exceeded 120 degrees F. The administrator stated he would work with MD-A to correct it. A policy on maintaining and monitoring water temperature from resident bathroom sink faucets was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure hot water temperatures in resident areas were maintained between 105 - 115 °F. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report audit findings to Quality Assurance Performance Improvement (QAPI) committee for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710		

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21880	Continued From page 12	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		3/31/25

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21880	Continued From page 13 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow their grievance process for missing personal property for 1 of 1 resident (R1) who reported a missing item. Findings include: R11's admission Minimum Data Set (MDS) assessment dated 12/23/24, indicated R11 was cognitively intact, no behaviors, very important to choose what clothes to wear, dependent on staff for dressing and diagnoses included after care following joint replacement surgery. On 3/9/25 at 11:22 a.m., R11 stated she had a jean jacket that was missing. R11 stated the jacket was put in the laundry and never returned. R11 stated she informed multiple staff about the missing jean jacket and had not heard back about the missing jacket. R11 stated the missing jacket was at least thirty dollars. On 3/10/25 at 7:26 a.m., social services (SS)-A stated R11 reported a missing jean jacket over two weeks ago and she helped search R11's room and other staff looked throughout the facility for the jacket. SS-A stated she looked in laundry and other resident rooms for the jacket and the jacket was not found. SS-A stated a form was filled out regarding the missing jacket. SS-A was observed to look for the paper form in her office	21880	Corrected	

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CENTRAL HEALTH CARE CENTER	444 NORTH CORDOVA LE CENTER, MN 56057

(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
21880	Continued From page 14 and confirmed she could not find the form. SS-A stated she had seen R11 wear the jean jacket prior to her reporting the jacket missing. SS-A stated the process for missing items was a form was filled out, the missing item was discussed in IDT (interdisciplinary team) meeting, and the administrator was made aware. SS-A confirmed the IDT team and administrator was not made aware as expected, and follow up wit R11 had not occurred. On 3/10/25 at 7:31 a.m., laundry (L)-C stated she had been aware of R11's missing jean about a month ago but had not been able to locate the jacket. L-C indicated social services follows up with the residents. On 3/10/25 at 10:28 a.m., the administrator stated social services was expected to follow the policy regarding missing clothing and make him aware when a resident reported a missing item. The administrator confirmed he was not made aware of R11's report of the missing jacket. The administrator confirmed the missing item process was not followed through. Facility Missing Item Policy and Procedure dated 3/1/21, indicated Social service department will complete a missing item report Social service department will begin an investigation to locate the missing items and will inform the IDT at the following morning meeting of the missing item report. If the item is unable to be located, social services will discuss with the administrator possible alternatives to replace the missing item. Social services will notify the residents representative of the missing item if its unable to be located immediately with the 5-day	21880		

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21880	Continued From page 15 investigation person. Social services will office possible alternative to replace the missing item. The facility administrator will sign off of the report once the investigation is finalized, the report will be filed in the residents soft file in the social service office. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to grievances to ensure grievances are acted upon and the resident given a resolution to the identified grievance. The DON, social worker, or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure grievances are acted upon and the resolution notification is made to the resident and/or family. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

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	245401	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/12/2025. At the time of this survey, Central Health Care 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		03/21/2025

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. Central Health Care is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1969, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 40 beds and had a census of 26 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing that the emergency lighting in the facility had been tested annually for 90 minutes within the last year. 2. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by staff interview that emergency lights were only being tested for 3 seconds each on monthly tests. An interview with the Maintenance Director	K 291	K291-Emergency Lighting (NFPA 101 Sections 19.2.9.1, 7.9.3.1.1) Corrective Action: All battery-backed emergency lights were tested on 3/13/25 with a 90-minute full-duration test. Any units that failed or lacked charge for the full duration are being repaired or replaced immediately. Monthly function tests have been extended to at least 30 seconds (in line with code) and documented. Measures to Prevent Recurrence: The Maintenance Director has implemented a preventative maintenance schedule to perform and log monthly 30-second tests and annual 90-minute tests of all emergency lighting units, as required by NFPA 101. Maintenance staff have been re-trained on proper testing procedures and record-keeping.	3/31/25

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K 291	Continued From page 3 verified these deficient findings at the time of discovery.	K 291	Monitoring: The maintenance director will maintain an Emergency Lighting Test Log and review it after each monthly and annual test to ensure compliance. The Administrator will audit this log quarterly to verify tests are completed on schedule and any issues are promptly addressed. Results will also be reviewed at the facility's quarterly safety committee meetings for ongoing oversight. Responsibility: Maintenance Director is responsible for performing the tests, replacing faulty equipment, and maintaining documentation. The administrator is responsible for oversight, ensuring the testing schedule is followed, and allocating resources for timely repairs. Completion Date: March 31, 2025- all emergency lights have been tested and necessary repairs/replacements completed. Ongoing monthly and annual testing will continue per schedule.	
K 321 SS=E	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	K 321		3/31/25

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K 321	Continued From page 4 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) 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 rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that the door to the soiled utility room attached to the laundry room would not positively latch when closed. 2. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that the door to the nursing storage that exceeded 50 square	K 321	K321-Hazardous Areas-Enclosure (NFPA 101 Section 19.3.2.1) Corrective Action: The door to the soiled utility room (laundry area) was adjusted and repaired on 3/13/25 to ensure it positively latches when closed. The improper flip-down hold-open device on the nursing supply storage room door was removed immediately, and the door's self-closing mechanism was tested to confirm it closes and latches every time. Measures to Prevent Recurrence: Maintenance has inspected all hazardous area doors (soiled utility, laundry, storage rooms, etc) facility-wide to verify they are self-closing and latching. Any deficiencies	

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K 321	Continued From page 5 feet was being held open with a flip down device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 321	have been corrected. Going forward, no door will be propped open with unapproved devices-staff have been in-serviced on the requirement to keep hazardous area doors closed and latched for fire containment. Monitoring: The Maintenance Director will include hazardous room door checks in daily rounds for one month and then every six months thereafter. These checks (ensuring doors are closed, not wedged, and latching) will be logged. The administrator will review the door-check logs every six months and also spot-check hazardous area doors during routine walking rounds. Any recurrence of doors not self-closing or latching will be corrected immediately and addressed with staff. Responsibility: Maintenance director is responsible for door maintenance (adjustments, repairs) and for conducting regular door inspections. The administrator is responsible for enforcing staff adherence (no door wedging) and providing oversight to ensure the maintenance program keeps all hazardous are doors compliant. Completion Date: March 13, 2025-immediate repairs completed and hold open-device removed. Policy enforcement and staff re-education on door safety completed by this date. Ongoing monitoring is in place.	
K 324 SS=F	Cooking Facilities	K 324		3/31/25

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K 324	Continued From page 6 CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.5, 9.2.3, and NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2. These deficient findings	K 324	k324-Cooking Facilities Corrective Action: Maintenance director called Central Fire on 3/18/25 and they are sending the missing report supporting documentation that the range hood suppression is inspected every 6 months, bringing it up to date. Additionally, the door from the kitchen to the dining room	

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K 324	Continued From page 7 could have a widespread impact on the residents within the facility. Findings Include: 1. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed during documentation review that the facility could not provide documentation that the range hood suppression system was being inspected every 6 months. 2. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that the door from the kitchen to the dining room was be held open with a flip down device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	had its improper floor-mounted hold open removed on 3/13/25. The door is now kept closed and its self-closing devices was tested to ensure it closes properly after each use. Measures to Prevent Recurrence: The facility established a standing service agreement for biannual hood suppression inspections (every 6 months per NFPA 96). The Maintenance Director added these due dates to the preventative maintenance calendar to ensure no inspection is missed. All staff were in-serviced on keeping the kitchen-dining door closed. Monitoring: The Maintenance Director will maintain inspection records for the hood suppression system and verify the service is performed every six months. A log of these inspections will be reviewed by the Administrator after each service. The administrator or Maintenance Director will also check during monthly safety rounds that the kitchen door is not propped open and closes properly. Any non-compliance (e.g. finding an unapproved door wedge) will result in immediate staff re-education. Responsibility: Maintenance Director is responsible for scheduling and overseeing the hood suppression system's inspections/maintenance and for ensuring the kitchen door's self -closure is functional. The administrator is responsible for staff compliance with the fire plan (keeping fire doors closed) and for verifying that all required kitchen safety	

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K 324	Continued From page 8	K 324	inspections are completed on schedule. Completion Date: March 31, 2025-hood suppression system inspection will send inspection report and kitchen door hold-open corrected. Ongoing semi-annual inspections and monitoring procedures are in effect as of this date.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3 and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, 14.4.5, 14.4.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed during a review of available documentation that the facility could not provide a annual fire alarm report.	K 345	K345-Fire Alarm System Testing & Maintenance Corrective Action: Measures to Prevent Recurrence: The facility has entered into an annual service contract with the fire alarm company to ensure the system is inspected and tested at least every 12 months per code requirements. The Maintenance Director has implemented a tracking system for fire alarm maintenance-including scheduling the next annual test well in advance and tracking any device repairs. Any deficiencies noted in inspection	3/31/25

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K 345	Continued From page 9 2. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed during a review of available documentation that the deficiencies from the sensitivity report had not been corrected. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 345	reports will be corrected within 5 business days and documented. Monitoring: The Maintenance Director will maintain a Fire Alarm Maintenance Log containing the date of each annual test, results, and any corrective actions taken. The Administrator will review this log and the official inspection reports annually (each time a new report is issued) to verify that no inspections are missed and that all issues have been addressed. Additionally, the facility's QA committee will review fire alarm compliance annually to ensure sustained performance. Responsibility: Maintenance Director is responsible for coordinating annual fire alarm testing and promptly completing any repairs or corrections identified. The Administrator is responsible for oversight, ensuring that the contract is in place, funds are available for repairs, and that documentation of compliance is maintained for surveyor review. Completion Date: March 31, 2025-Annual fire alarm test completed and all past deficiencies corrected. The annual testing schedule and monitoring processes are now in place going forward.	
K 353 SS=F	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,	K 353		3/31/25

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K 353	Continued From page 10 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 by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system 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, sections 5.1.1.2, and 5.3.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the five-year sprinkler inspection had been completed at the time of the survey. 2. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that the	K 353	K353-Sprinkler System Maintenance & Testing Corrective Action: The facility immediately addressed all cited sprinkler maintenance issues. Maintenance Director contacted Summit on 3/13/25 and was told that Summit will be at the facility by the end of March to conduct the overdue 5 year internal inspection of the sprinkler system. Additionally, the missing ceiling tiles in the boiler room and generator room were replaced on 3/13/25, restoring the integrity of the ceiling so that fire sprinklers and fire/smoke barriers in those areas function as designed. Measures to Prevent Recurrence: The Maintenance Director updated the Preventative Maintenance Schedule for the sprinkler system to include all periodic requirements per NFPA 25-including	

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K 353	Continued From page 11 gauge on the fire sprinkler riser had not been replaced within the last 5 years. 3. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that there were missing ceiling tiles in the boiler room and in the generator room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	monthly, quarterly annual and 5-year inspections/tests. A reminder system is in place so that 5 year tasks (such as internal pipe inspections and gauge replacements) are tracked well in advance of their due date. After any work by contractors, maintenance will verify that ceiling tiles or fire barriers are restored (there is now a checklist step to inspect above ceiling areas post service work). Furthermore, maintenance staff have been briefed to report any displaced ceiling tiles immediately so they can be fixed at once. Monitoring: The Maintenance Director will maintain sprinkler system service records and review them quarterly to ensure all required inspections are up-to-date. A quarterly visual inspection of all sprinkler riser gauges and a spot check of ceiling tile integrity in mechanical rooms will be conducted and logged. The Administrator will review compliance with sprinkler maintenance during the facility's quarterly safety committee meetings-checking that no inspection has been missed and that any noted issues (like missing tiles or needed repairs) were promptly handled. Responsibility: Maintenance Director is responsible for coordinating all sprinkler system inspections/tests and for performing routine visual checks of sprinkler components and enclosures. Maintenance Director will also ensure any contractor performing work above ceilings restores fire stopping and tiles. The Administrator is responsible for providing	

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K 353	Continued From page 12	K 353	support (scheduling and funding the contracted inspections) and for oversight to verify that the sprinkler maintenance program remains in full compliance. Completion Date: March 31, 2025-five year sprinkler inspection will be completed by the end of month. Gauge replaced, and ceiling tiles installed. All corrective actions will be completed by the end of March and enhanced ongoing maintenance schedule is implemented.	
K 372 SS=D	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 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 barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility.	K 372	k372-Subdivision of Building Spaces (Smoke Barrier Integrity) Corrective Action: The identified unsealed penetration in the North Wing smoke barrier was sealed on 3/14/25 using an approved firestop material with a 1/2-hour	3/31/25

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K 372	Continued From page 13 Findings include: On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that there was an unsealed penetration in the smoke barrier located at the North wing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	fire rating, restoring the smoke barrier to its proper integrity. Maintenance conducted a comprehensive inspection of all smoke barriers in the facility on 3/14/25 - 3/15/25 to check for any other penetrations or gaps. Any additional small penetrations found (e.g. around conduits or pipes) were also sealed immediately with appropriate firestop caulk. Measures to Prevent Recurrence: We have reinforced our facility policy that any work involving wall penetrations (for cabling, plumbing, etc.) must include proper firestopping before the task is considered complete. The Maintenance Director will inspect all contractor work areas before sign-off to ensure compliance. Maintenance Staff will inspect above ceiling areas along smoke barriers quarterly to catch any new penetrations or deterioration. Monitoring: Quarterly logs will be reviewed by the Adminstrator during quarterly safety meetings. Additionally, after any renovation or contractor work, the Administrator will verify (with the Maintenance Director) that a follow-up inspection of affected barriers was done and documented. This dual sign-off (Adminstrator and Maintenance) will ensure no pentration goes unsealed. Responsibility: Maintenance Director is responsible for performing and documenting smoke barrier inspections and sealing any penetrations promptly. The Administrator is responsible for	

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K 372	Continued From page 14	K 372	ensuring this process is part of the facility's quality assurance program and that no work by contractors or staff compromises a smoke barrier without immediate remediation. Completion Date: March 31, 2025-the citied penetration has been sealed and a full facility sweep for similar issues completed. Ongoing quarterly inspection protocol is now in place.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the patients within the facility. Findings include:	K 711	K711-Evacutation and Relocation (Fire Safety) Plan Correction Action: The facility's written fire safety plan was reviewed and updated on 3/18/25 to fully comply with NFPA 101 requirements. The plan now clearly details the method of fire alarm transmission to	3/31/25

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K 711	Continued From page 15 On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include the transmission of the fire alarms to the fire department. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 711	the fire department and emergency forces. The facility fire alarm system is monitored 24/7 by an alarm company that dispatches the fire department; this procedure is now explicitly described in the plan. The plan already addressed evacuation procedures, staff responsibilities, and other required elements, and these were verified for completeness during the review. Following the update, all staff were in-serviced on 3/18/25 regarding the revised fire plan, emphasizing the new content about alarm transmission and their duties during a fire. Measures to Prevent Recurrence: The fire safety plan will be reviewed annually (and after any significiant facility change) by the Administrator and Maintenance Director to ensure it remains comprehensive and up-to-date. We have incorporated this annual review into our safety committee calendar each year. Additionally, staff will receive refresher training on the fire plan at least annually and after any revision. Fire drills conducted on each shift quarterly will incorporate verification that staff understand the alarm communication procedure. Monitoring: The Administrator will maintain the fire plan document and training records. Completion of the annual plan review and staff re-training will be tracked in our quality assurance performance improvement (QAPI) program. The administrator or Maintenance Director will also audit fire	

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K 711	Continued From page 16	K 711	drill reports to ensure that any issues noted (e.g. staff unsure of alarm procedures) are corrected with additional training. The Maintenance Director will ensure a copy of the current fire plan (with all required components) is readily available at the nurse's station and that staff can locate and explain it if asked. Responsibility: Administrator is responsible for updating the fire plan, coordinating staff training, and ensuring overall compliance with emergency planning regulations. The Maintenance Director (who also serves as Safety Officer) is responsible for assisting in the plan's development and review, conducting fire drills, and ensuring the fire alarm monitoring service remains active and functioning as described in the plan. Both will collaborate to enforce staff adherence to the plan. Correction date: March 31, 2025-Fire Safety Plan updated and staff re-educated on emergency procedures (including alarm transmission). Annual review schedule established going forward.	
K 761 SS=F	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	K 761		3/31/25

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K 761	Continued From page 17 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/12/2025 between 10:00 and 1:15 PM, it was revealed by a review of available documentation that a fire door inspection has not been conducted within the last 12 months. 2. On 03/12/2025 between 10:00 and 1:15 PM, it was revealed by observation that the fire doors between the D-wing and chapel did not shut completely when released from the magnetic door hold open device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 761	K761-Fire Door Maintenance, Inspection and Testing Corrective Action: A comprehensive inspection of all fire-rated doors in the facility was completed by the Maintenance Director on 3/14/25/ This included corridor doors, smoke barrier doors, and any other fire doors. The inspection identified the Chapel/D-Wing cross-corridor doors (cited in the survey) as not fully closing-these doors were adjusted on 3/14/25 (the magnetic hold-open devices were tested and the door closer tension adjusted) to ensure they reliably close and latch when released. All other fire doors were tested; any minor issues (e.g. a gap adjustment or hinge lubrication) were corrected during the inspection. There is now documentation on file of this initial fire door inspection and the repairs made. Measures to Prevent Recurrence: The facility has implemented an annual fire door inspection program in accordance with NFPA 80. The Maintenance Director will perform (or arrange) a formal fire door inspection every 12 months and maintain written records of each inspection and any	

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K 761	Continued From page 18	K 761	corrective actions. This schedule has been added to our preventative maintenance calendar. staff have been educated to report any doors that are not closing properly immediately, rather than waiting for the annual check. Additionally, the magnetic hold-open devices throughout the facility are now tested monthly during fire drills to ensure they release and the doors close. Monitoring: The Maintenance Director will keep a Fire Door Inspection Log, including the date of annual inspections and any deficiencies found/fixed. The Administrator will verify completion of the annual door inspection by signing off on the log each year and reviewing the findings. As part of routine life safety rounds (quarterly), the Administrator and Maintenance Director will randomly spot-check a sample of fire doors to ensure they are in proper working order. Any door found deficient between scheduled inspections will be fixed immediately and noted in the log for trend tracking. Responsibility: Maintenance Director is responsible for conducting the annual fire door inspections, performing needed maintenance on door hardware, and ensuring all fire door assemblies (including closers and hold-open devices) function correctly. The Administrator is responsible for oversight of this program, ensuring that inspections occur on schedule and that resources are provided for timely repair or replacement of door	

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K 761	Continued From page 19	K 761	components. Both the Administrator and Maintenance Director share responsibility for enforcing that fire doors are never obstructed and remain operable at all times. Completion Date: March 31, 2025-all fire doors inspected and adjusted as needed (including the cited chapel corridor doors). Annual inspection schedule and monthly door closer testing are in place going forward.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 914		3/31/25

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K 914	Continued From page 20 by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide updated documentation for resident room electrical receptacle testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	K914-Electrical Systems Maintenance and Testing Corrective Action: The facility conducted a complete test of all resident room electrical outlets on 3/17/25 - 3/20/25 to ensure they are functioning safely and meeting NFPA 99 requirements. Using an outlet tester, the Maintenance Director checked each patient bed outlet for correct polarity, grounding and retention force. All outlet were found to be functioning properly; no replacements were needed. Documentation of this receptacle testing (including date, room locations, tested and results) has been recorded and placed on file. Measures to Prevent Recurrence: We have established a policy that all resident care area receptacles (outlets in patient rooms and any other patient care vicinity) that are not hospital grade will be tested at least annually for grounding continuity and tension, per NFPA 99 2012 guidelines. This annual testing interval has been added to the facility's perventative maintenance schedule (next due 3/26). If any receptacle is serviced or replaced in the interim, it will be tested upon installation as well. Monitoring: The Maintenance Director will maintain an Electrical Receptacle Testing Log with the results of each annual test cycle. The Administrator will review this log annually to ensure all required outlets were tested and that any deficiencies	

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K 914	Continued From page 21	K 914	were corrected. Additionally, during monthly maintenance rounds, the Maintenance Director will spot check a few random outlets (especially in high-use areas) to catch any emerging issues proactively. These spot checks will be noted in the maintenance records. Responsibility: Maintenance Director is responsible for performing (or supervising) the required outlet testing and ensuring any outlets that fail are promptly replaced with code complaint devices. The Administrator is responsible for oversight of this testing program, confirming it occurs annually and that records are properly kept. The Administrator will also ensure that any new construction or remodeling uses hospital grade receptacles as required or otherwise adheres to the testing protocol if standard outlets are used. Completion Date: March 31, 2025-initial facility wide receptacle safety testing completed with all outlets passing. Annual testing is scheduled moving forward to maintain compliance.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the	K 916		3/31/25

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K 916	Continued From page 22 emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the annunciator for the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.1.1.17 and 6.4.1.1.17.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that there was not a generator annunciator installed for the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 916	k916-Essential Electrical System Alarm Annunciator (Genterator) Corrective Action: The Maintenance Director located the annunciator panel. It was found on the East service hallway before the double doors next to the exit sign. Completion Date: March 20, 2025 was when the Maintenance Director located the annuciator panel.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		3/31/25

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	245401	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE CENTER	**444 NORTH CORDOVA** **LE CENTER, MN 56057**

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K 918	Continued From page 23 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 4.2. This deficient finding could have a widespread impact on the residents within the facility Findings include: On 03/12/2025 between 10:00 AM and 01:15 PM, it was revealed by a review of available documentation at the time of the survey the	K 918	K918-Essential Electrical System Maintenance and Testing (Generator) Corrective Action: The Maintenance Director found the facility's Letter of Reliability letter from our natural gas supplier, CenterPoint which is dated from 2016. The Maintenance Director placed the letter in the Life Safety Book that is located in the maintenance shop. Completion Date: March 13, 2025 was when the Maintenance Director found the letter and placed it in the Life Saftey Book.	

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K 918	Continued From page 24 facility could not provide a letter of reliability from the gas company. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918		
K 920 SS=F	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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health	K 920	K920-Electrical Equipment (Power Cords and Extension Cords)	3/31/25

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K 920	Continued From page 25 Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that a power-strip was plugged into a extension cord in room 106. 2. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that a fan was plugged into an extension cord in room 304. 3. On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that two extension cords were being used in the MDS Coordinator room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	Corrective Action: The specific improper uses of improper uses power strips and extension cords cited have been corrected as of 3/12/25. In room 106, the power strip that was plugged into an extension cord was unplugged and the equipment is now plugged directly into a wall outlet. In room 304, the fan that was plugged into an extension cord is not plugged directly into a wall outlet (the extension cord was removed). In the MDS Coordinator's office, the two daisy chained extension cords were removed completely; a multi-outlet power strip (UL-1363 rated) was provided if additional outlets are needed for office equipment, or additional permanent outlets will be installed by an electrician. After these fixes, the Maintenance Director conducted a facility wide audit on 3/13/25 of all resident rooms and offices to identify and remove any other inappropriate extension cords or daisy chained power strips. Any non-compliant cords found were removed, and appliances were either plugged directly into permanent outlets or into a single approved power strip as appropraite. Measures to Prevent Recurrence: The facility has implemented a strict Electrical Cord Usage Policy-extension cords are not allowed for permanent equipment or continuous use in resident care areas-they may only be used temporarily (under 8 hours) and must be removed immediately after use. Power strips are permitted only for low power consumer electronics in resident rooms (ex: TVs,	

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K 920	Continued From page 26	K 920	radios) and must be UL-approved; they cannot be plugged into another power strip or extension cord. For any medical equipment or high power devices, only permanent outlets or UL 1363A medical grade power strips are allowed. Staff (and able residents) have been educated on 3/21/25 about these rules and were asked to report or surrender any extension cords in use. The facility will also provide additional wall outlets or approved power strips as needed to eliminate the temptation to use unapproved cords. Monitoring: The Maintenance Director will perform monthly safety rounds in resident rooms and offices to ensure compliance with the no extension cord policy. These rounds include checking behind furniture and equipment for unauthorized cords or daisy chains. Findings will be logged on a Power Cord Inspection Checklist. The Administrator will review this log monthly. Additionally, room inspections will be incorporated into the weekly environmental checks by nursing staff, who will alert maintenance if they notice an extension cord or improper power strip usage in a resident's room. Any infraction will result in immediate removal of the cord and re-education of the staff/resident involved. Trends or repeated issues will be discussed in the safety committee to identify further preventive measures. Responsibility: The Maintenance Director is responsible for enforcing the electrical cord policy-removing unauthorized cords, providing safe alternatives, and	

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K 920	Continued From page 27	K 920	conducting routine inspections. The Administrator is responsible for ensuring all staff and residents are informed of the rules, and for handling any non-compliance from a policy enforcement perspective. The Administrator will also support installation of additional permanent outlets by a licensed electrician in areas that are identified as needing more capacity (to prevent future misuse of extension cords. Completion Date: March 31, 2025-all identified improper cords removed and facility wide audit completed. Policy implemented and staff training done by 3/21/25. Ongoing monitoring is active as of the completion date.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual	K 923		3/31/25

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K 923	Continued From page 28 cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper storage of oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, sections11.3, 5.1.3.1.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/12/2025 between 10:00 AM and 1:15 PM, it was revealed by observation that oxygen cylinders were being stored without being identified by full or empty signs. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	k923-Gas Equipment (Oxygen Cylinder Storage) Corrective Action: The oxygen storage room was immediately brought into compliance on 3/12/25. Specifically, all oxygen cylinders in storage have been segregated into separate, clearly labeled areas marked as "full" or "empty." Any cylinder that is partially used, but not yet empty, is treated as "in use" and kept with full cylinders until completely exhausted. Once exhausted it is moved to the empty storage area. Additionally, we verified that the storage room has appropriate, precautionary signage on the door (it did: "No Smoking-Oxygen in Use" Mechanical gases-No Smoking or Open Flame"	

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K 923	Continued From page 29	K 923	"Oxygen Transfilling-No Smoking"), and that all portable cylinders were secured from tipping (they were). Measures to Prevent Recurrence: The facility's Oxygen Handling Policy has been updated to require that, when cylinders become empty, staff label cylinders as "empty" and move them to the designated empty storage area. Nursing and maintenance staff have been in-serviced regarding this new policy. We have also implemented an "Oxygen Inventory Log" for when new, full tanks are received. New full tanks will be placed in the "full" area in order of delivery (first-in, first-out usage). When a cylinder is taken for use, staff will log it out, and when returned empty, staff will tag it as "empty" and place it in the empty area. Empty cylinders will be removed from the facility regularly (picked up our current supplier during deliveries) to prevent accumulation. Our previous supplier has been notified to remove their accumulated cylinders from our oxygen storage room. Monitoring: The Maintenance Director (who oversees medical gas storage) will inspect the oxygen storage area weekly to ensure compliance. Weekly checks will include verifying that full and empty cylinders are properly separated and labelled. Weekly checks will be documented in a Medical Gas Storage Checklist. The Administor will review this checklist monthly and also spot-check the storage room during faciiltly rounds. Any deviation (eg, an unlabeled cylinder or an	

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K 923	Continued From page 30	K 923	empty cylinder in the full rack) will be corrected on the spot, and staff retraining or counseling will occur to ensure compliance. We will also include a review of oxygen storage in our quarterly safety committee agenda to verify sustanined adherence. Responsibility: The Maintenance Director is responsible for the safe storage of oxygen cylinders, including maintaining the labeling system and conducting regular inspections of the storage area. The Administrator is responsible for ensuring staff (maintenance and nursing alike) follow these guidelines. Completion Date: March 31, 2025-Immediate action was taken place to separate full and empty oxygen cylinder tanks. The Maintenance Director contacted our previous supplier who states they will pick up cylinders not in use from our oxygen storage room. Nursing and Maintenance staff have been educated. Ongoing monitoring will take place.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 28, 2025

Administrator
Central Health Care Center
444 North Cordova
Le Center, MN 56057

RE: CCN: 245401
Cycle Start Date: March 10, 2025

Dear Administrator:

On April 25, 2025, 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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

April 28, 2025

Administrator
Central Health Care Center
444 North Cordova
Le Center, MN 56057

Re: Reinspection Results
Event ID: 8SHQ12

Dear Administrator:

On April 25, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 10, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us