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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D2HP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00764

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245569**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/03/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 11/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Certification Specialist — 02/17/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/08/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245569 November 17, 2017

Ms. Angela Nelson, Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

Dear Ms. Nelson:

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

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

Effective October 17, 2017 the above facility is recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 17, 2017

Ms. Angela Nelson, Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

RE: Project Number S5569028

Dear Ms. Nelson:

On September 29, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 15, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 3, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 23, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 15, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 17, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 15, 2017, effective October 17, 2017 and therefore remedies outlined in our letter to you dated September 29, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

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ID: D2HP

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/15/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE-NE II 10/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 11/08/2017 (L20)

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

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

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 29, 2017

Ms. Angela Nelson, Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

RE: Project Number S5569028

Dear Ms. Nelson:

On September 14, 2017, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 24, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 24, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 December 14, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 14, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	09/15/2017 **09/14/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/11/17, 9/12/17, 9/13/17, and 9/15/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 156		10/17/17

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

Electronically Signed | 10/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	09/14/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1 (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	09/14/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2	F 156		

and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	09/14/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 3 information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	09/14/2017

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F 156	Continued From page 4 admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident	F 156		

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F 156	Continued From page 5 before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 156		

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F 156	Continued From page 6 Based on interview, and document review, the facility failed to ensure provide the required Medicare Liability and appeal notices upon termination of skilled services for 1 of 3 residents (R31) reviewed for liability notices. Findings include: R31's facility records lacked evidence the facility provided neither of the Medicare A Non-Coverage (CMS-10123) or the Demand Bill Form (CMS-10124) or any other accepted Medicare A Benefit papers at the end of R31's Skilled Medicare A treatment period. R7 was re-admitted to the facility on 5/18/17, after an acute hospitalization, and was taken off Medicare A benefits while still in the nursing home on 6/13/17. The record further lacked evidence R31 (or representative) was provided with the opportunity to request a demand bill evidenced by lack of a completed Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form CMS 10055. R31's Minimum Data Set (MDS) dated 5/18/17, indicated R31 had returned from an acute care hospital and qualified for Medicare Part A skilled services. R31's Therapist Progress and Discharge Summary report dated 6/13/17, indicated R31 had received physical therapy services for therapeutic exercise, gait training, and transfers. The summary also indicated R31 had met his therapy goals and was discharged from skilled	F 156	Correction: It is the policy of Halstad Living Center to provide each Resident with notification of services; including appropriate notices of Medicare Part A noncoverage. A CMS form for R31 was discussed verbally with Resident's sister via telephone and a copy of the original was mailed via certified mail. Medicare notification forms have been added to the weekly Medicare meeting outline for discussion/tracking. This is to ensure that notification and documentation is given to the Resident or Res representative within 48 hours prior to discontinuation of the services which are covered by the Medicare benefits. Education: CMS Regulations and Policy was reviewed with staff responsible for issuance of Form 10123, 10124, and CMS R131 on Oct 4, 2017 (Medicare team members including DON, MDS coordinator , RN-Resident Care Coordinator, business office manager, therapy representative, HIM's coordinator , and Social Services.) Audits: Potentially affected current residents in the last 3 months who were on skilled services through Medicare and would have required notice, with correction of any identified as being out of compliance. Weekly audits will be conducted of current residents receiving Medicare services. These audits will be completed by the Medicare team weekly and brought to the QA committee by the DON quarterly until 100% compliance is achieved for 6 months.	

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F 156	Continued From page 7 therapy services on 6/13/17. On 9/12/17, at 2:30 p.m. director of nursing (DON) stated she was the person responsible for providing the required Medicare forms. The DON verified R31's medical record lacked the required forms and indicated she had thought she had mailed out the forms to R31's representative for signature. On 9/15/17, at 8:29 a.m. the DON confirmed she had not sent the forms certified mail so there was not a receipt and did not document in the medical record when R31 (or representative) had been notified of the termination of skilled services. Facility policy was requested and not received.	F 156		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (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. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (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	F 166		10/17/17

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F 166	Continued From page 8	F 166		

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 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

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F 166	Continued From page 9 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 implement their grievance policy and procedure related to reporting, investigation and response of missing personal property for 1 of 2 residents (R44) who reported missing cosmetics. Findings include:	F 166	Correction: It is the policy of Halstad Living Center that each 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. It is also the policy of Halstad Living Center that all staff must address the resident grievances immediately within	

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F 166	Continued From page 10 R44's quarterly Minimum Data Set (MDS) dated 6/20/17, indicated R44 had intact cognition. On 9/12/17, at 11:07 a.m. R44 stated her lipstick and eyeliner went missing out of her bathroom, however she could not recall the date the items went missing but confirmed it had been within the last couple of months. R44 stated there was a couple of residents in the facility who liked to wander into other people's rooms and one especially liked to take things that did not belong to them. R44 stated she had reported the missing items to a nurse (she did not know which one) and since the time of the report, staff had not followed up with her about the status of her missing items. R44's behavior note dated 8/5/17, at 2:06 p.m. indicated another resident was found digging through resident's makeup drawer. R44 stated she was missing a lipstick and thinks the other resident may have mistakenly taken it. Facility grievance and missing item reports were reviewed and did not reflect a report or investigation of R44's missing cosmetics. On 9/14/17, at 1:12 p.m. nursing assistant (NA)-F confirmed knowledge of R44's missing lipstick and eyeliner and thought they had went missing a couple of months ago. NA-F recalled searching for the items in the rooms of other residents who wandered into other resident rooms.	F 166	their scope and authority and report such grievances to their supervisor and the grievance official. Corrective action taken for R44 included formal action by the grievance official. This initiated the grievance process which included an investigation and follow up in accordance to facility policy and procedure. Education: Corrective action also includes: re-education of staff regarding follow-up on a residents' concerns/wishes/grievances when they are expressed verbally or in writing. All staff in- servicing/reeducation will be completed on or before Oct 17, 2017 regarding the facility's policy and procedure for the grievance process. SSD / designee will review the grievance policy with all staff annually and will be reviewed with new employees upon hire. SSD will review the grievance policy with current residents at the next council meeting, and individually with the residents that do not attend the next meeting, and each resident council meeting thereafter as part of the regular meeting agenda. The grievance policy will also be reviewed with new residents/resident representative upon admission. Audit: monthly audits will be conducted by the SSD and results will be brought to the QA committee quarterly for further review until 100% compliance is reached and sustained for 6 months.	

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F 166	Continued From page 11	F 166		

-At 1:30 p.m., NA-J also reported an unawareness of R44's missing cosmetic items.

-At 2:06 p.m. registered nurse (RN)-B stated she remembered hearing about the lipstick and confirmed staff searched for the item, however did not find it. RN-B stated a missing item and/or grievance report was supposed to be filled out and given to the social worker with a copy being placed on a clipboard at the nurses station for all staff to view and help to look for the missing item/s. The social worker was responsible to complete the investigation and follow up with the resident. However, RN-B was not aware if a missing item and/or grievance report had been completed for the missing make-up.

-At 2:29 p.m., NA-H reported an unawareness R44 had been missing cosmetics, and explained missing items were to be reported to a nurse.

-At 2:41 p.m., NA-I reported an unawareness R44 had been missing cosmetics, and explained missing items were to be reported to a nurse.

-At 2:23 p.m. licensed practical nurse (LPN)-D verified she was the nurse who wrote the behavior note on 8/5/17, and stated she had not filled out the missing items report because she thought it had already been reported.

On 9/15/17, at 8:42 a.m. director of nursing (DON) stated a missing item report was supposed to be filled out and given to the social work designee for investigation and follow-up. The DON stated she expected a form be completed for every missing item.

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F 166	Continued From page 12 -At 9:15 a.m. social service designee (SSD) stated she had not received a written report of R44's missing make-up items therefore had not conducted an investigation or followed up with R44 to see if the items were found or not. The SSD confirmed a missing item report should have been completed and communicated to staff to look for the items and an investigation should have been conducted with a follow up with R44. Facility policy Grievance Policy dated 3/15/17, identified the SSD as the designated grievance official. The policy informed staff, grievances could be given to any staff member who would then forward the grievance to the SSD and the staff member who received the complaint shall immediately attempt to resolve the complaint within their role and authority and if it could not be resolved immediately the employee shall report to their supervisor and the SSD. The SSD would review the grievance and determine if it was reportable to the State agency and initate an investigation. The policy further indicated the facility would take immediate action to prevent further potential violations of any resident's rights while the alleged violation was being investigated and the facility would strive for prompt resolution in a reasonable time frame which was determined by all parties involved. The policy directed the SSD to complete a written response to the resident or resident representative which included the findings of the investigation.	F 166		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities,	F 242		10/17/17

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F 242	Continued From page 13 schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure individual sleep time preferences were accommodated for 1 of 2 residents (R2) who was not allowed the opportunity to chose his morning wake time. Findings include: R2's admission Minimum Data Set (MDS) dated 8/1/17, indicated R2 was alert, oriented and required extensive assistance of two staff for bed mobility and transfers. The assessment also indicated R2 was able to indicate his own preferences for his daily routine. On 9/12/17, at 11:00 a.m. R2 stated the staff assisted him out of bed too early. R2 explained that while at home, he did not rise before 10:00 a.m. but while at the facility, the staff had to assist him out of bed earlier than that in order to get to	F 242	F242 Correction: It is the policy of Halstad Living Center that all residents have a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care. The resident has a right to make choices about aspects regarding his or her life in the facility that are significant to the resident. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. R2 received a reassessment of preferences and the comprehensive care plan was reviewed and updated to include a specific time for his waking preferences. In order to ensure no other residents are affected by this deficient practice, the SSD/Designee will review each resident□s preference list with each	

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F 242	Continued From page 14 breakfast. R2 stated he did not like to rise before 10:00 a.m. On 9/12/17, at 4:00 p.m. R2 again stated he preferred to sleep in until 10:00 a.m. R2 stated the staff wake him around 7:00 a.m. to ensure he was able to get to the dining room for breakfast. Family member (FM)-A who was visiting with R2, confirmed R2's daily routine at home included watching the 10:00 p.m. news and he usually did not get out of bed before 10:00 a.m. R2's Miscellaneous Consent and Preference List form dated 8/1/17, indicated the social service designee (SSD) had asked R2 when he preferred to get out of bed. The SSD had indicated "late." The list did not identify a specific time or what R2 considered "late." R2's care plan dated 8/10/17, indicated R2 required assistance with activities of daily living due to weakness. The care plan did not identify R2's preference to sleep until 10:00 a.m. On 9/13/17, at 8:20 a.m. R2 was observed sleeping in bed. At 8:26 a.m. R2 was observed fully dressed, seated in a wheelchair and being assisted to the dining room by a nursing assistant (NA). - At 9:08 a.m. NA-D wheeled R2 from the dining room back to his room. NA-D stated R2 was routinely in the dining room for breakfast by 8:30 a.m. NA-D stated any resident was able to sleep	F 242	resident or resident representative by 10-17-17 and quarterly thereafter as a part of the quarterly assessment. If changes are identified, the resident care plan will be revised and staff will be educated in regards to changes. Education: All nursing staff were educated on 10/4 and 10/5/2017 regarding R2□s assessment of preferences and the comprehensive care plan was reviewed and is current including wake preferences. All nursing staff were also educated at this time to include all other resident□s right to choice. All other entities of staff will be educated on resident□s right to choose on or before 10/17/2017. Audits: The SSD will conduct monthly audits of resident choices, including wake times. Audit results will be brought to the QA committee quarterly for further review until 100% compliance is reached and sustained for the 6 months.	

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F 242	Continued From page 15	F 242		

in as long as they wanted but R2 always ate breakfast in the dining room. NA-D confirmed breakfast was served between 7:00 a.m. to 9:00 a.m. daily.

- At 12:15 p.m. trained medication assistant (TMA)-A stated all residents' had the choice to sleep in if they wanted. TMA-A stated R2 did sleep in daily as he did not routinely get out of bed until 8:00 a.m.

- At 12:40 p.m. registered nurse (RN)-B stated any resident was able to sleep in as long as they wished, however they had to inform staff as to when they wanted to get up.

- At 1:00 p.m. the SSD stated she completed the daily preference list with each resident upon admission. She confirmed R2 had expressed the desire to get up "late." However, she did not ask R2 what "late" meant to him. The SSD stated she communicated R2's preferences to the nursing assistants verbally but did not add the preference to the care plan. The SSD stated she was unaware R2 wanted to sleep in later in the mornings. The SSD questioned NA-G as to the time R2 routinely arose in which NA-G replied R2 was usually assisted with cares at 8:00 am.

On 9/14/17, at 2:05 p.m. RN-A stated resident preferences should be communicated to the direct care staff verbally and also added to the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	09/14/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 16 The Accommodation of Needs policy dated 5/2016, directed the staff to ensure the residents individual needs and preferences were accommodated to the extent possible except when health and safety of the individual or other residents would be endangered.	F 242		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was easily accessible in order to summons for staff assistance for 1 of 13 residents (R6) observed throughout the survey to be unable to reach the call light. Findings include R6's Diagnoses Report dated 9/15/17, indicated R6's diagnoses included hereditary spastic paraplegia, schizophrenia, cataract, macular degeneration, glaucoma, farsightedness, and dementia.	F 246	Correction: It is the policy of Halstad Living Center that each resident has a right to be treated with respect and dignity, including: the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents. It is the right of all residents to have a call light within reach and accessible of their being when in their rooms. Corrective action for R6 included immediate re-education with the CNA involved on 9/13/17 and all other staff involved for that day. Education: All nursing staff were re-educated on 10/4 and 10/5, 2017 regarding accommodation of needs and	10/17/17

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F 246	Continued From page 17 R6's annual Minimum Data Set (MDS) dated 8/15/17, indicated R6 had moderate cognitive impairment and required extensive assistance from two staff members for activities of daily living (ADL's) that involved mobility. R6's ADL care plan dated 6/14/16, indicated R6 had a self-care deficit related schizophrenia and hereditary spastic paraplegia, and had poor safety awareness. The care plan directed staff to remind R6 to call for assistance as needed. R6's fall care plan revised on 8/17/17, indicated R6 had limited physical mobility and directed staff to not leave R6 unattended related to attempts at self-transfers and to place the call light within reach of resident at all times while in his room (6/14/16). On 9/11/17, at 5:33 p.m. R6 was observed in his room, seated in his wheelchair, near the end of his bed facing the door. R6's call light button was clipped to the cord at the outlet which was on the wall towards the end of the bed. The amount of space between the bed and the wall was approximately two feet. R6 stated his call light was on the wall, however he was not able to reach it because there was not enough room for his wheelchair to move in order to be able to reach it. At 5:40 p.m. licensed practical nurse (LPN)-A verified the call light was not within R6's reach and proceeded to reposition the call light on R6's lap and stated the call light was supposed to be placed within his reach. On 9/13/17, at 12:15 p.m. R6 was observed in his room, seated in his wheelchair, near the end of	F 246	call light placement. All other staff will be re-educated on or before 10/17/2017. Audit: Weekly and random spot checks will be conducted by DON/designee, a monthly audit report will be reviewed at the QA committee quarterly meeting for further review until 100% compliance is reached and sustained for 6 months.	

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F 246	Continued From page 18 his bed facing the door. R6's bed was turned down. R6's call light was not visible. R6 stated his call light was somewhere wrapped up in the bedding and he was unable to move the bedding enough to look for look it. - At 12:17 p.m., registered nurse (RN)-A verified the call light was not within R6's reach and proceeded to locate the call light which was wrapped in R6's bedding and placed it in R6's lap. RN-A stated the call light was supposed to be placed within easy reach. -At 12:18 p.m., nursing assistant (NA)-C confirmed she had turned down R6's bed but had left the room to assist another resident and accidentally did not put the call light within R6's reach. On 9/18/17, at 8:36 a.m. the director of nursing (DON) stated it was the expectation for all residents to have their call lights within easy reach in order to summons for assistance. Facility policy Bed Making: Unoccupied, last revised 9/2003, included place call light within resident's reach.	F 246		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to	F 280		10/17/17

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F 280	Continued From page 19	F 280		

request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

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F 280	Continued From page 20 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to identify when hospice services were to be provided for 1 of 1 resident (R53) who received hospice services without knowledge of when hospice was to visit. In addition, the facility failed to revise the care plan to include the use of a wheelchair for 1 of 3 residents (R21) reviewed for	F 280	Correction: It is the policy of Halstad Living Center to complete a comprehensive care plan within seven days after completion of the comprehensive assessment; prepared by the IDT that includes the attending physician, a registered nurse and other appropriate staff in disciplines as	

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F 280	Continued From page 21 activities of daily living. Findings include: On 9/12/17, at 3:30 p.m. R53 stated in the past year she had been diagnosed with endometrial cancer and had been receiving hospice services prior to her admission to the facility. R53 stated while she was at home, she had an idea as to when the hospice staff would be visiting her, however, since being at the facility, she was no longer aware of when the hospice staff would be visiting her. R53 stated the hospice staff had visited her about once a week, but it may be up to ten day before they visited again. R53 stated she did not know when they would be visiting next. R53's care plan dated 8/28/17, indicated R53 was receiving end of life care and received hospice services. The care plan did not identify what services hospice would provide or when they would be at the facility. R53's Hospice of the Red River Valley careplan dated 8/29/17, indicated R53 was receiving hospice care for pain management, spiritual services and family support. The care plan did not identify how often hospice services would be provided. On 9/13/17, at 12:35 p.m. nursing assistant (NA)-E stated she was aware R53 received hospice services but she had no idea when the hospice staff visited or what they did for R53. NA-E stated there was no scheduled for R53's hospice services.	F 280	determined by each resident's needs, and if practicable, the participation of the resident, family, or legal representative, and periodically reviewed and revised by a team of qualified persons with each assessment. Immediate corrective action taken for R53 was to communicate with hospice agency to develop a hospice plan and coordination of care. This plan includes all services provided by hospice, a schedule of dates and times of visits, including all hospice disciplines (i.e. RN, LSW, Chaplin, CNA, etc.) The schedule for services will be relayed to R53 by the facility. R53's care plan was revised to identify what services are provided by hospice. DON/designee and MDS coordinator will review all current residents care plans regarding hospice services to ensure that the care plans reflect their current services and coordination of care. Immediate corrective action for R21 included revision of R21 care plan to reflect his use of a wheelchair. DON/designee and MDS coordinator will review all current residents care plans regarding assistive devices for mobility to ensure that the care plans reflect their current assistive devices. The facility has developed a communication tool regarding care plan revisions that will be monitored daily by DON/designee and MDS coordinator. Education: All staff will be reeducated on or before 10/17/2017 regarding care plan revisions. Audit: monthly audits will be completed to report to QA committee quarterly meetings for further review until 100%	

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F 280	Continued From page 22 - At 1:25 p.m. the social service designee (SSD) stated R53 had been receiving hospice services prior to her admission to the facility. The SSD stated she was unaware of how often the hospice staff visited the resident at the facility but was aware R53 was to receive nursing services and visits from the hospice social worker. - At 1:35 p.m. licensed practical nurse (LPN)-C stated the hospice nurse visited R53 an average of once a week but did not provide personal care services, therefore, the nurses and the social workers visited as needed. LPN-C confirmed the hospice staff did not communicate with the facility as to when they would be visiting with R53. - At 1:40 p.m. RN-A stated the hospice staff visit with R53 about weekly, however the hospice staff did not inform R53 or the facility prior to coming to the facility. RN-A stated if facility staff had questions related to R53's cares, they were to call the hospice service directly. RN-A reviewed R53's care plan and confirmed the plan did not identify what services would be provided for R53. - At 2:10 p.m. hospice RN (HRN)-A was interviewed via telephone. HRN-A stated she visited with R53 every 7 to 10 days, however, due to the fluctuation of the hospice services, HRN-A did not schedule specific times to visit with each of the hospice clients, rather made sure the residents were seen on a regular basis. HRN-A confirmed when R53 was admitted to the facility, R53 was no longer notified as to when she would	F 280	compliance is reached and sustained for 6 months.	

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F 280	Continued From page 23	F 280		

receive the hospice visits. HRN-A stated the hospice service had recently been equipped with a new electronic medical record software system and the hospice staff had not yet received education on the software therefore, the care plans were not accurate and did not reflect how often they would be visiting R53. HRN-A stated she would develop a schedule to ensure R53 and the facility would be aware of R53's hospice service schedule.

The Medical Care policy dated 5/2015, indicated when a resident participate in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directive for managing pain and other unforgettable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status.
R21's care plan was not revised to reflect his use of a wheelchair.

R21's undated Care Plan indicated R21's mobility needs varied from independent to required supervision with the use of a four wheeled walker (FWW). The Care Plan goal dated 4/21/17, was for R21 to maintain independence for mobility needs through the next review. The Care Plan directed staff R21's transfer and locomotion needs varied from independent to required supervision with FWW. The Care Plan directed staff to assist as needed, provide stand-by assistance with ambulation with the FWW and report any changes, problems or concerns regarding mobility to the charge nurse. The Care Plan lacked indication of R21's use of the

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F 280	Continued From page 24	F 280		

wheelchair.

On 9/12/17, at 3:36 p.m. R21 was observed seated in a wheelchair, in the dining room, independently drinking coffee and eating a snack.

On 9/13/17, at 7:15 a.m. R21 was observed sitting quietly in a wheelchair in the common area, fully dressed for the day.

-At 7:45 a.m. R21 was observed to be wheeled to the dining room by licensed practical nurse (LPN)-D, placed up to the table, and assisted to put on a clothing protector. R21 proceeded to independently drink from a glass on the table.
-At 8:23 a.m. R21 propelled himself in the wheelchair down the hall, using his feet.
-At 8:39 a.m. R21 sat in his wheelchair in the common area. He was continuously observed seated with his hands folded in his lap.
-At 9:05 a.m. NA- E wheeled R21 to his room and assisted him to the bathroom. NA-E stated R21 used to be more independent but now required more assistance. NA-E stated the facility had obtained R21 a wheelchair a couple of months ago.

On 9/13/17 at 11:52 a.m. R21 was observed in the dining room, seated in a wheelchair, eating his meal independently.
-At 12:14 p.m. a staff member wheeled R21 to just outside the door of the dining room.

On 09/14/17, at 11:13 a.m. NA-K wheeled R21 to the dining room via wheelchair.

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F 280	Continued From page 25 On 9/14/17, at 1:29 p.m. NA-F stated a couple months ago, R21 had begun wobbling when ambulating with the walker so the facilty had gotten him a wheelchair due to the his unsteadiness when on his feet. On 9/15/17, at 8:54 a.m. registered nurse (RN)-B confirmed R21 had been using a wheelchair and stated the care plan should have been revised to include its us. The Use of Care Plans/Revisions policy dated 6/2017, indicated changes in the resident's condition must be reported to the MDS [minimum data set] Assessment Coordinator so a review of the resident's assessment and care plan can be made. The policy also indicated documentation must be consistent with the resident's care plan.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 309		10/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 26 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the coordination of hospice care for 1 of 1 resident (R53) who was receiving hospice services without knowledge of when the hospice services would be provided. Findings include: R53's admission Minimum Data Set (MDS) dated 8/28/17, indicated R53 was alert and oriented, had diagnosis of malignant endometrial cancer, anxiety and depression. The MDS also indicated R53 required extensive assistance with all	F 309	Correction: It is the policy of Halstad Living Center to provide the fundamental principles and standards of Quality of Life and Quality of Care. It is also the policy of Halstad Living Center that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and care plan. It is policy of Halstad Living Center that based on the comprehensive assessment of a resident, the facility must ensure that residents received treatment	

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F 309	Continued From page 27 activities of daily living and received hospice care. R53's Activities of Daily Living Care Area Assessment (CAA) dated 9/1/17, indicated R53 required extensive assistance with all activities of daily living and staff were to meet R53's needs along with the help of Hospice services. On 9/12/17, at 3:30 p.m. R53 stated she had been diagnosed with endometrial cancer in the past year and had been receiving hospice services prior to her admission to the facility. R53 stated while she was at home, she had an idea as to when the hospice staff would be visiting her, however, since being at the facility, she was no longer aware of when the hospice staff would be visiting her. R53 stated the hospice staff had visited her about once a week, but it may be up to ten day before they visited again. R53 stated she did not know when they would be visiting next. R53's care plan dated 8/28/17, indicated R53 was receiving end of life care and received hospice services. The care plan did not indicate what services would be provided or when they would be at the facility. R53's Hospice of the Red River Valley care plan dated 8/29/17, indicated R53 was receiving hospice care for pain management, spiritual services and family support. The care plan did not identify how often hospice services would be provided. R53's Hospice Progress Notes, indicated R53 had received a social service visit	F 309	and care in accordance with the professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Immediate corrective action for R53 regarding coordination of care of Hospice services included communication with the Hospice Agency to ensure that the facility would be notified of the services to be provided to R53, as well as a schedule of said services and R53 was provided the schedule. Education: Hospice of the Red River Valley was educated on the above stated principles of Quality of Life and Quality of Care and the need for coordination of care between this facility and the agency. A plan was put in place immediately to ensure that the facility and R53 were made aware of when Hospice services would be visiting R53 and ensure that R53 is aware of her own care. Please see plan of correction for F 280 for further information. In addition, all facility staff will be educated on or before October 17, 2017 regarding coordination of care with hospice and the fundamental principles and standards of providing care that attains or maintains each residents' highest practicable well-being. Audits: Monthly care plan audits of coordination of care of hospice services will be conducted by the MDS Coordinator/Designee and reported to the QA committee quarterly for further review until 100% compliance is reached and sustained for 6 months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 28	F 309		

on 8/28/17 and 9/5/17. The hospice registered nurse (RN) had visited with R53 on 8/29/17, 9/7/17, and 9/12/17.

On 9/13/17, at 12:35 p.m. nursing assistant (NA)-E stated she was aware R53 received hospice services but she had no idea when the hospice staff members visited or what services they provided R53. NA-E stated there was no schedule for R53's hospice services.

- At 1:25 p.m. the social service designee (SSD) confirmed R53 had been receiving hospice services prior to her admission to the facility and was aware R53 was to receive nursing services and visits from the hospice social worker while R6 resided in the facility. However, the SSD stated she was unaware of how often the hospice staff visited R53 at the facility.

- At 1:35 p.m. licensed practical nurse (LPN)-C stated the hospice nurse visited R53 an average of once a week. LPN-C stated the hospice staff did not provide personal care services, therefore, the hospice nurses and the social workers visited as needed. LPN-C confirmed the hospice staff did not communicate with the facility as to when they would be visiting with R53.

- At 1:40 p.m. RN-A stated the hospice staff visited with R53 about weekly. RN-A confirmed the hospice staff members had not informed R53 or the facility as to when they would be visiting. RN-A stated if facility staff had questions, they were directed to call the hospice service. RN-A

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	245569	A. BUILDING _____ B. WING _____	09/14/2017

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F 309	Continued From page 29 reviewed R53's care plan and confirmed the plan did not identify what hospice services would be provided for R53. - At 2:10 p.m. hospice registered nurse (HRN)-A was interviewed via telephone. HRN-A stated she visited with R53 every 7 to 10 days, however, due to the fluctuation of the hospice services, HRN-A did not schedule specific times to visit with each of the hospice clients, rather made sure each were seen on a regular basis. HRN-A confirmed while at home, R53 was provided a timeline or notification as to when hospice staff would be visiting, however when R53 was admitted to the facility those notifications ceased. HRN-A stated the hospice service had recently been equipped with a new electronic medical record software system and the hospice staff had not received education on it therefore, the care plans were not accurate and did not reflect how often they would be visiting R53. HRN-A stated she would develop a schedule to ensure R53 and the facility would be aware of when hospice services would be visiting R53 to ensure R53 was aware of own her care. The End of Life Care policy dated 5/2015, directed the facility and hospice, with input from the resident and family to establish a coordinated plan of care which reflect s and support the hospice philosophy.	F 309		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 431		10/17/17

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	245569	A. BUILDING _____ B. WING _____	09/14/2017

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F 431	Continued From page 30	F 431		

them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

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F 431	Continued From page 31 (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were stored securely in 1 of 1 medication room observed. This had the potential to affect all 39 residents residing in the facility. Findings include: On 9/15/17, at 9:50 a.m. housekeeper (HSKP)-A was observed to open the locked medication room by punching numbers into the key pad electronic door lock. Once the door was opened, HSKP-A entered the medication room and shut the door. - At 10:00 a.m. HSKP remained in the medicaiton room. At this time, licensed practical nurse (LPN)-B opened the medication room by entering numbers into the key pad. She observed HSKP-A emptying the garbage. LPN-B left the medication room door open as HSKP-A wiped off the medication counters. LPN-B stated only licensed nurses and the trained medication assistant (TMA) were to have access to the medication	F 431	Correction: It is the policy of Halstad Living Center that only persons authorized to prepare and administer medication are to have access to the medication room, including any keys and door access codes. Immediate corrective action of this deficient practice was to change the door access code. The access code was changed by the RN in charge and the new code was provided only to those that are authorized to prepare and administer medications. Other immediate corrective action included re-education of housekeeping staff that are not allowed access to the medication room. Education: All staff will be re-educated on or before October 17, 2017 regarding facility policy and procedure for medication room access. Audit: Monthly and random audits will be conducted by the charge nurse and reported to the DON to bring to the quarterly QA committee for further review for 6 months to ensure compliance in maintained.	

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F 431	Continued From page 32	F 431		

room and she was unaware the housekeeping staff had access to medication room.

- At 10:01 a.m. the medication room was observed to have an approximate two foot by one foot plastic container of prescription medication placed on the counter. The box contained approximately 40 bottles/cards of prescription medications which included, but was not limited to diuretics, antidepressants, and bronchodilator's, and anticoagulant medications. A stock medication cupboard was also observed to have multiple bottles (greater than 75) of over the counter stock medication which included vitamins, laxatives, pain relievers and supplements. The medication refrigerator was observed to contain several doses of pneumovax solution, tuberculin solution, suppositories, insulin, a removable small locked box which contained liquid Ativan. The plastic box, the stock cupboard and the refrigerator were not seperately locked, which allowed anyone who entered full access to all of the medications.

- At 10:02 a.m. HSKP-A stated she routinely cleaned the medication room and removed the garbage. HSKP-A stated it was part of her daily routine to enter the medication room by herself and clean it. HSKP-A stated she could not recall whom had given her the access code to the medication room and felt it was common knowledge the housekeeping staff had access to the room. HSKP-A confirmed she was not authorized to prepare and administer medications.

- At 10:25 a.m. registered nurse (RN)-B stated RNs, LPNs, TMAs, and pharmacy consultants

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 33 were the only employees who were to have access to the medication room. - At 10:36 a.m. the director of nursing (DON) stated only staff authorized to pass medications were allowed in the medication room and the nursing staff were to clean the medication room, not housekeeping staff. The DON stated she was unaware unauthorized staff members has access to the medication room. The Medication Storage policy dated 8/2003, indicated only persons authorized to prepare and adminsitered medication were to have access to the medication room which included any keys and door access codes.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not	F 441		10/17/17

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F 441	Continued From page 34	F 441		

limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store,

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F 441	Continued From page 35 process, and transport linens so as to prevent the spread of infection. (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 develop and maintain an ongoing, comprehensive infection control program which included investigation, prevention, control, surveillance and reporting of disease and infection. This had the potential to affect all 44 residents who resided in the facility. Findings include: On 9/15/17, at 11:13 a.m. licensed practical nurse (LPN)-A and the director of nursing (DON) were interviewed regarding the facilty infection control program. LPN-A indicated she was the current infection preventionist for the facility. LPN-A indicated she had been in the role for a few months and had taken over the role from the DON. Both LPN-A and the DON stated the facility had no documentation available related to the tracking or surveillance of resident infections and verified the facility lacked a system for surveillance and tracking of resident infections. The Surveillance policy dated 8/2017, indicated it was the facility policy to utilize process and outcome surveillance in order to identify potential clusters of infections, changes in prevalent organisms, or note increases in the rate of	F 441	Correction: It is the policy of Halstad Living Center to maintain and ensure an ongoing, comprehensive infection control program which includes investigation, prevention, control, surveillance and reporting of disease and infection for all residents, staff, volunteers, visitors, and other individuals under a contractual arrangement. Based on interview and document review, Halstad Living Center failed to document infections of Residents, including those treated by antibiotics in real time documentation. Infection control logs were not completed which could negatively impact all residents of the Halstad Living Center. A Surveillance Policy was established on 8/17/2017 for monitoring any outbreaks in infections, and outlining what infections to track including those infections that are not treated by antibiotics. This policy is also a way for staff to notify the Infection Preventionist / designee of suspected infections. Educations: Nursing staff will be educated in a mandatory nursing meetings on 10/4 and 10/5, 2017 and all staff will be educated on or before 10/17/2017 regarding the importance of real time tracking of infections, filling out the surveillance log, and any potential	

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F 441	Continued From page 36 infection in a timely manner. The policy indicated all residents were monitored for the risk of infection and for the presence of actual infections. The policy indicated process surveillance involved the observation of the individual steps of resident care and environmental interactions. The policy also indicated outcome surveillance was designed to identify and report all evidence of an infection and consisted of collecting/documenting data on individual cases and comparing the collected data to standard written criteria of infections. The policy further directed the facility would track prevalence of infections or the number of cases of a disease occurring at a specific time while taking into account the number of residents at risk for developing that same illness at the same time. If trends or clusters were noted an action plan would be put into place. The Surveillance Reporting policy dated 8/2017, indicated once surveillance was completed, the data was to be collected and analyzed and the significance was to be summarized. The resulting information would be shared with those who assisted in infection prevention which may include internal and external sources.	F 441	breaches in infection control. They will also be educated on the new Surveillance policy. Formal education will be conducted to those employees found to have a breach in infection control as PRN basis. Annual infection control education will be provided for all employees. Audits: Formal audits will be done on a PRN basis for outbreaks in infection and will be documented and reported to QA committee at quarterly meetings. Formal audits will be conducted on a weekly basis to ensure that infection logs are filled in correctly for monitoring of outbreaks of infections, and will be documented and reported to QA committee quarterly.	

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	245569	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshal Division. At the time of this survey Halstad Living Center 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/05/2017

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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	245569	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2017**

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

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K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Halstad Living Center was built in 1977 as a 1-story building without a basement and was determined to be Type II (000) construction. In 1990 a 1-story addition to the dining room was constructed to the east of the original building and was determined to be Type II (111) construction. In 1998 a dining addition was constructed to the west of 200 wing and an addition to the south to connect to the apartment building. These additions are 1 story without a basement and were determined to be of a Type II (111) construction. The building is divided into 5 smoke zones with 1/2 hour fire rated barriers.

The entire building is sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system that includes corridor smoke

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	245569	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2017**

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K 000	Continued From page 2 detection, with additional detection in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code". Hazardous areas have automatic fire detectors that are on the fire alarm system. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building. The facility has a capacity of 44 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING 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. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Separation N/A — Automatic Sprinkler	K 321		9/15/17

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	245569	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2017**

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K 321	Continued From page 3 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 STANDARD is not met as evidenced by: Based on observation and staff interview the facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of staff and visitors. Findings include: At 9:55 am on 09/13/2017 observations revealed the space around two conduits in the mechanical room was not properly fire stopped. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 321	On 9-15-17 fire caulk was replaced around the two identified conduits. An additional 26 areas were also repaired and re-caulked in the mechanical room.	
K 324 SS=D	NFPA 101 Cooking Facilities 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,	K 324		9/18/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 4 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 STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to install the protection devices of the cooking equipment as stated in the Life Safety Code (NFPA 101) 2012 edition section 9.2.3 & NFPA 96 section 10.5.1. This deficient practice could allow for the spread of fire if staff could not reach the device, affecting an undetermined amount of staff and visitors. Findings include: At 10:02 on 09/13/2017 observations revealed the pull station for the ANSUL system was not located a minimum of 10 feet from the stove. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 324	On 9-18-17, Summit Company completed a work order in which the pull station for the ANSUL system was moved at least 10 feet from the stove. Work was completed on 9-18-17.	

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	245569	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2017**

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K 345	Continued From page 5	K 345		
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain the smoke detection system as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.2.10.1.1 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, section 29.10. This deficient condition could delay alarm notification in case of a fire and affect all 44 residents and an undetermined amount of staff and visitors. Findings include: At 8:10 am on 09/13/17 documentation review revealed the smoke detector sensitivity report indicated the laundry room smoke detector failed and was not replaced. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 345	On 9-20-17, work order #49654 was completed by Protection Systems to replace the smoke detector in the laundry room. Testing of the smoke detector passed inspection.	9/20/17
K 712	NFPA 101 Fire Drills	K 712		9/18/17

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K 712 SS=F	Continued From page 6 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 44 residents and an undetermined amount of staff and visitors. Findings include: At 8:15 am on 09/13/2017 record review revealed two there was no documentation for two fire drills, one on the 1st shift in the first quarter and one on the 2nd shift in the 3rd quarter of 2017. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 712	Effective 9-18-17 unscheduled fire drills will occur on each shift, each month. Fire drill training will be held separate from the unscheduled fire drills.	
K 751	NFPA 101 Draperies, Curtains, and Loosely	K 751		10/5/17

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K 751 SS=E	Continued From page 7 Hanging Fabr Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This STANDARD is not met as evidenced by: Based on observation and staff inteview the facility failed to provide fire retardent curtains as described in the Life Safety Code, NFPA 101, section 10.3.1. This deficient condition could cause faster spread of fire affecting evacuation of 16 of the 44 residents and an undetermined amount of staff and visitors. Findings include: At 10:47 on 09/13/2017 observations revealed a plastic shower curtain hung over the closet opening in resident room 304. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 751	The shower curtain on the closet in room 304 was immediately removed. A fire retardant curtain was order from Direct Supply and the expected delivery date is 10/5/2017. This fire retardant curtain will be hung as soon as it is received.	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		9/15/17

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K 920	Continued From page 8 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 STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2..4.2.1 and the use of power strips comply with 10.2.3.6. This deficient practice could affect and an undetermined amount of staff and visitors. Findings include: At 11:00 on 09/13/2017 observations revealed in the Human Services office (301) an air conditioner plugged into a power strip that was connected to an extension cord. This deficient condition was confirmed by the Facility Administrator and the Director of	K 920	On 9/15/17, the power strip was removed from room 301. The air conditioning unit was also removed and an additional power source will be added to accommodate an air conditioning unit in the future.	

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K 920	Continued From page 9 Maintenance.	K 920		