



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
April 8, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

RE: CCN: 245537
Cycle Start Date: March 25, 2025

Dear Administrator:

On March 25, 2025, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 24, 2025, the situation of immediate jeopardy to potential health and safety cited at F578-Request/refuse/dscntnue Trmnt;formlte Adv. Dir. was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 23, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 23, 2025, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 23, 2025, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 23, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Minnewaska Community Health Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 23, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met. delete the section if SQC is cite.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the

deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

LeAnn Huseeth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseeth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 September 25, 2025 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at

(312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

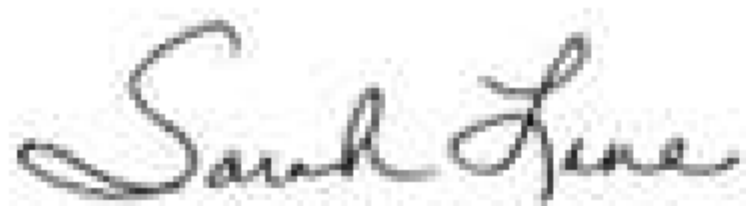
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 8, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

Re: State Nursing Home Licensing Orders
Event ID: DGX711

Dear Administrator:

The above facility was surveyed on March 23, 2025 through March 25, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseeth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseeth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 04/17/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
NAME OF PROVIDER OR SUPPLIER MINNEWASKA COMMUNITY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET STARBUCK, MN 56381		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 3/23/25 to 3/25/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 3/23/25 to 3/25/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F578 when the facility failed to follow the facility's policies and procedures and failed to ensure resident advance directives were accurately documented in the electronic health record to reflect the residents current wishes, which affected 1 of 30 residents. The IJ began on 3/6/25, and the immediacy was removed on 3/24/25. In addition to the recertification survey, the following complaint was reviewed: H55379429C (MN00111033) with no deficiency issued. The facility's plan of correction (POC) will serve	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/17/2025

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

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F 000	Continued From page 1	F 000			
F 578 SS=J	as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578			3/26/25

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F 578	Continued From page 2 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident advance directives were accurately documented in the clinical record to reflect the resident's current wishes which affected 1 of 30 residents (R9) reviewed for advanced directives. This deficient practice resulted in an immediate jeopardy (IJ) for R9 who would have received cardiopulmonary resuscitation (CPR), contrary to their wishes, in the absence of a pulse or respirations. The IJ began on 3/6/25, when R9's electronic health record (EHR) banner and orders identified R9 was to have CPR however, R9's updated physician's order for life sustaining treatment (POLST) signed on 1/23/25, identified R9's wishes of do not resuscitate (DNR). The administrator, assistant administrator and director of nursing (DON) were notified of the IJ on 3/23/25, at 5:49 p.m. The IJ was removed on 3/24/25, at 11:35 a.m.,when the facility had implemented corrective action, however	F 578	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The code status of R9 was verified and entered consistently into all relevant locations within the electronic medical record. 2. Identification of other residents having the potential to be affected was accomplished by: Determining the code status or presence/absence of Advance Directives		

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F 578	Continued From page 3 non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R9's admission Minimum Data Set (MDS) dated 1/30/25, identified R9 was cognitively impaired and had diagnoses which included dementia, asthma, and hypertension (elevated blood pressure). Identified R9 was dependent on staff for activities of daily living (ADLs) which included bed mobility, toileting, and transfers. R9's current POLST signed by family member (FM)-A on 1/23/25, identified R9's wishes were DNR. The POLST was scanned into her EHR and signed by her medical provider on 1/30/25. Review of R9's current EHR Order Summary Report signed by her medical provider on 3/6/25, identified R9 had an order for CPR even though R9's POLST identified DNR. Review of R9's EHR banner on 3/23/25 at 1:12 p.m., identified R9 wanted CPR. Review of R9's face sheet in the EHR undated identified R9 was admitted to the facility on 1/24/25. Identified R9 wanted CPR. R9's care plan revised 2/6/25, identified R9 wanted CPR. Identified the POLST would be reviewed quarterly and as needed. Review of a facility report sheet dated 3/23/25 -3/29/25, located at the nurses station identified R9 wanted CPR.	F 578	is required for all residents. Therefore, all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing Services- Assistant director of nursing educated licensed nurses regarding the documentation procedures for Advance Directives/Code status. A chart audit of all residents was completed on 03/23/2025. There were no further discrepant findings. 4. Education: Education completed with nursing staff that POLST will be completed on admission and sent to provider for signature. Nurse completing POLST will call provider for a telephone order at time of admission to implement code status change at time of admission. Order will be double checked by two nurses. When POLST is signed by provider and returned, the nurse receiving the signed order will again, verify that the order is correctly documented in all the relevant sections of the medical record.. Order will be initialed by two nurses verifying all steps have been met when processing the order. Code status will be reviewed quarterly at resident care conference and as needed or requested. Nurses will verify code status with current order and the POLST when reviewing for PCP rounds, transfer, ect. Staff who were not present at time of education were contacted via telephone by Director of Nursing Services, and provided education on all of the above. Nurses were educated to look for		

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F 578	Continued From page 4 During an interview on 3/23/25 at 2:39 p.m., FM-A stated she had signed the POLST on 1/23/25, stating that R9's wishes were to be DNR. During an interview on 3/23/25 at 4:19 p.m., licensed practical nurse (LPN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the EHR banner and would have proceeded accordingly. LPN-A verified R9's banner identified R9 wanted CPR. LPN-A verified there was a discrepancy between R9's banner and the POLST. During an interview on 3/23/25 at 4:22 p.m., registered nurse (RN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the report sheet located at the nurses station and would have proceeded accordingly. RN-A verified R9's report sheet identified R9 wanted CPR. RN-A verified there was a discrepancy between R9's report sheet and the POLST. During an interview on 3/23/25 at 4:24 p.m., RN-B indicated in the event a resident did not have a pulse or respirations, he would refer to the EHR banner and would have proceeded accordingly. RN-B verified R9's banner identified R9 wanted CPR. RN-B verified there was a discrepancy between R9's banner and the POLST. During a joint interview on 3/23/25 at 4:41 p.m., assistant director of nursing (ADON) and DON stated upon admission, all residents were assigned a full code (CPR) status. ADON and DON stated a POLST was then completed with all residents or resident representatives and sent off to the provider for a signature. ADON and	F 578	code status on the resident banner in the EHR. 5. How the corrective action(s) will be monitored to ensure the practice will not reoccur: For a period of three months, the Director of Nursing Services or designee will perform weekly medical record audits of new admissions and those residents on the MDS assessment schedule for consistent documentation of the resident's Advance Directive/Code status throughout the electronic medical record. After the three-month period, routine random audits will be completed by Director of Nursing Services or designee. All Advance Directives/Code status will be reviewed during Resident Care Conference, the MDS Coordinator will audit with completion of each MDS. All Results of the audits will be discussed monthly with the QAA committee until such time it is determined that substantial compliance is maintained. Corrective action completion date: 03/24/25.		

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

PRINTED: 04/17/2025
FORM APPROVED
OMB NO. 0938-0391

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F 578	Continued From page 5 DON confirmed there was a discrepancy with R9's banner and current physician orders which identified R9 was a full code and did not match her current wishes of being DNR. ADON and DON confirmed in the event R9 did not have a pulse or respirations, CPR would have been initiated against R9's wishes. DON indicated she would expect staff to follow the POLST, resident wishes and the facility policy. Review of a facility policy titled Code Status Policy revised 5/21/21, identified the facility would follow a policy regarding a resident's right to request, refuse, and/or discontinue medical treatment and to formulate an advance directive. Identified the POLST would have been documented in the EHR. Further identified the code status would have been reviewed with Care Conferences at least quarterly and documented in the medical record. The IJ was removed on 3/23/25 at 11:35 a.m., when the facility developed and implemented a systemic removal plan which was verified by interview and document review: -All residents' records were reviewed to ensure the POLST form, the electronic medical records were updated to ensure resident's wishes for advance directives, were accurate on 3/23/25. -R9's EHR record was updated to match the current POLST. -All current licensed staff were educated on the policy for advance directives, updating the POLST and the EHR to reflect the resident's wishes on 3/24/25, as evidenced by the education sign in sheet and interviews.			F 578			

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F 578	Continued From page 6	F 578			
F 689 SS=D	-A process was implemented to assure all other nursing staff completed mandatory education prior to the start of their next shift on 3/24/25, by notification of required education via phone/text. All staff would sign off once education had been completed. -The advance directive policy was reviewed and determined no changes were required. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cleaning chemicals were secured away in a locked cabinet or cart, which had the potential to affect all residents residing on the B-wing (8 rooms - B-39, B-40, B-41, B-42, B-43, B-44, B-45, B-46). Additionally, it had the potential to affect 2 of 30 (R22 and R10) who were observed walking down the hallway. Findings include: R22's quarterly Minimum Data Set (MDS) dated 1/3/25, identified R22 was severely cognitively impaired and had diagnoses which included	F 689	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Immediate actions were completed on 3.23.25, systemic changes were implemented on 4.15.25, and monitoring		4/15/25

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F 689	Continued From page 7 dementia, traumatic brain injury (TBI) and alcohol dependence. Identified R22 was independent with transfers and mobility. R22's care plan revised 3/23/25, identified R22 had wandering behaviors. R10's annual Minimum Data Set (MDS) dated 2/14/25, identified R10 was severely cognitively impaired and had diagnoses which included dementia, depression, and glaucoma (difficulty with vision). Identified R10 was independent with transfers and mobility. R10's care plan revised 3/6/25, identified R10 had wandering behaviors. During observations the following was observed: -3/23/25 at 11:45 a.m., the tub/shower room door was propped open with the white trash can. Sitting to the right of the tub on the floor were two full bottles of vindicator+ (disinfectant/cleaner) one with no cap and the other closed with a cap. Sitting on the green rolling cart with hygiene supplies was one bottle of QT-TB (disinfectant/cleaner) 3/4 full in a spray bottle. Sitting on the tan rolling cart with hygiene supplies was a one bottle of Quarternary (Barrier II) based sanitizer 3/4 full in a spray bottle. The storage room B-50's door was open and one full bottle of pine liquid odor control was sitting on the floor in front of the wooden toiletry shelf. No staff were present down the hallway or at the nurses' station. -3/23/25 at 2:10 p.m., both doors remained open and chemicals remained in the same place.			F 689	and quality assurance initiatives commenced on 4.15.25, continuing until the QAPI committee determines substantial compliance. Education to the chemical storage policy and procedures were conducted for all staff by 4.17.25 Cleaning chemicals were immediately secured in a locked cabinet upon identification of the deficiency, and Residents R22 and R10 were assessed for any adverse effects due to potential exposure. Fortunately, no adverse effects were noted. A thorough inspection of all rooms and common areas was conducted to ensure no other unsecured chemicals were present, and immediate measures were implemented to secure all cleaning chemicals in locked cabinets or carts across the facility. The facility's policy on the storage and handling of cleaning chemicals was reviewed to require that all chemicals must be stored in locked cabinets or carts when not in use. Weekly audits of all storage areas will be conducted to ensure compliance with the chemical storage policy, and a log of audit results and corrective actions will be maintained. Monthly reviews of audit logs by the Quality Assurance Committee and quarterly reviews by the QAPI committee will help identify trends and areas for improvement. The Director of Nursing, environmental services director OR designee is responsible for implementing corrective actions, ensuring ongoing compliance.		

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F 689	Continued From page 8 -3/24/25 at 8:38 a.m., tub/shower room door continued to be propped open with the white trash can. Sitting to the right of the tub on the floor was one full bottle of vindicator+ and one empty bottle. Sitting on the white wire shelf above the tan rolling care was one bottle of QT-TB 3/4 full. The storage room B-50's door was open and one full bottle of pine liquid odor control was sitting on the floor in front of the wooden toiletry shelf. No staff were present down the hallway or ar the nurses station. -3/24/25 at 11:11 a.m., both doors remained open and chemicals remained in the same place. R22 walked down the hallway past both open doors to the exit. R22 remained at the exit door for approximately two minutes and walked back down the hallway past both open doors to another part of the facility. -3/24/25 at 1:39 p.m., both doors remained open and chemicals remained in the same place. -3/24/25 at 1:48 p.m., both doors remained open and chemicals remained in the same place. Nursing staff left the B-wing. - 3/25/25 at 7:25 a.m., tub/shower room door continued to be propped open with the white trash can. Sitting to the right of the tub on the floor was one full bottle of vindicator+ and one empty bottle. Sitting on the white wire shelf above the tan rolling care was one bottle of QT-TB 3/4 full. The storage room B-50's door was open and one full bottle of pine liquid odor control was sitting on the floor in front of the wooden toiletry shelf. No staff were present down the hallway or ar the nurses station.	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 9 -3/25/25 at 12:56 p.m., both doors remained open and chemicals remained in the same place. R10 wheeled in R10's wheelchair down the hallway past both open doors to the exit door. R10 remained at the exit door for approximately five minutes. R10 wheeled R10's wheelchair back down the hallway past both open doors to another area in the facility. -3/25/25 at 1:12 p.m., both doors remained open and chemicals remained in the same place. R22 walked down the hallway past both open doors to the exit. R22 remained at the exit door for approximately two minutes and walked back down the hallway past both open doors to another part of the facility. During an interview on 3/25/25 at 1:20 p.m., nursing assistant (NA)-A stated nursing staff cleaned and disinfected the tub after a resident had received a bath and before another resident would enter the tub. NA-A indicated both doors were to be shut after staff were finished cleaning and disinfecting the tub or getting supplies out of the storage area. When NA-A was finished talking with surveyor, NA-A left the B-wing and both doors remained open. During an interview on 3/25/25 at 1:55 p.m., director of nursing (DON) confirmed the above findings and stated the doors to both rooms were to be closed at all times. DON indicated neither room had a lock on the door and chemicals were not locked in a storage area. DON further indicated even if the doors were closed the chemicals would not be stored properly. DON stated having chemicals sitting out could have the potential for a harmful situation.	F 689			

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F 689	Continued From page 10 During an interview on 3/25/25 at 2:14 p.m. administrator confirmed the above findings and stated her expectations were chemicals were to be locked up and both doors were to be closed. The Hillyard material safety data sheet (MSDS) for Vindicator+ revised 2/4/21, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. The Hillyard MSDS for QT-TB revised 8/12/21, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. The Anderson Chemical Company MSDS for Barrier II revised 4/9/20, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. The Genlabs MSDS for Pine Odor Control revised 11/4/20, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred.	F 689			

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F 689	Continued From page 11 Facility policy titled Hazard Communication and Employee Right-to-Know dated 9/23, was to educate the employees of the hazardous substances, physical and infectious agents that may endanger their health and well-being while at work. Chemicals, through the different steps from their production to their handling, transport and use, may be a real danger for human health and the environment. People of any ages, from children to elderly, using many different languages and alphabets, belonging to various social conditions, including illiterates, were daily confronted to dangerous products (chemicals, pesticides, etc.)	F 689			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812			4/17/25

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F 812	Continued From page 12 Based on observation, interview and document review, food was not served in a sanitary manner for 30 residents who dined in the dining area observed during dining services and who received an afternoon snack. In addition, the facility failed to maintain the ice machine and the coffee machine in a sanitary manner to prevent potential illness for 30 residents who currently received ice from the ice machine and or coffee from the coffee machine in the dining area. Further, the facility failed to maintain proper holding food temperatures for cole slaw that was to be served during the evening meal for all residents in the dining room. These deficient practices had the potential to affect all 30 residents residing in the facility. Findings include: FOOD SERVICE During an observation on 3/23/25 at 11:51 a.m., activities aide (AD)-A was serving beverages in the dining room. AD-A was not observed to wash her hands and was not wearing gloves. AD-A picked up a glass off the table holding the top rim with her fingers, poured tomato juice into the glass and placed the glass on the table. AD-A picked up another glass holding the top rim with her fingers and poured water. AD-A picked up a coffee cup holding the top rim with her fingers and carried the cup over to the hot water for tea. AD-A then placed a clothing protector around a resident's neck and touched the resident's skin while closing the snaps on the back of the clothing protector around the residents neck. AD-A proceeded to pick up a glass holding the top rim with her fingers and poured milk. AD-A picked up three prefilled thickened glasses off of			F 812	The ice machine and coffee machine were immediately cleaned and sanitized, while the coleslaw was discarded, and an alternative item was served at the correct temperature to address the identified issue. The food service policy was revised to include the manufacturers recommended sanitation procedures for the ice and coffee machines, and a new cleaning schedule with weekly checks was implemented to ensure compliance. Additionally, the temperature log for all perishable food items was reviewed to ensure proper holding temperatures are maintained. Weekly audits of the dining area, ice machine, and coffee machine will be conducted to ensure compliance with sanitary standards, and temperature logs will be reviewed daily to ensure food is stored and served safely. The Food Services Director is responsible for overseeing the implementation of corrective actions, ensuring ongoing compliance, conducting regular audits, and reporting findings to the QAPI committee. Immediate corrective actions were completed on 3.23.25, with systemic changes and staff training to be finalized by 4.17.25. Ongoing monitoring began immediately and will continue indefinitely. All dietary staff received training on the updated food service policy and proper sanitation practices on 4.16.25, with sessions covering proper cleaning techniques for equipment and the importance of maintaining food temperatures. Records of all corrective		

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F 812	Continued From page 13 the beverage cart of milk and two juices. AD-A removed the plastic wrap off of the top rim of the three glasses with her fingers, held onto the top rim and placed each glass on the table. During an interview on 3/23/25 at 12:52 p.m., AD-A stated she usually poured the beverages at lunch time. AD-A confirmed she picked up the glasses and coffee cup holding the top rim with her fingers. AD-A stated she had not received any specific training on handling glasses and did not perceive handling the top rim of the glasses as a concern. During an observation on 3/23/25 at 2:28 p.m., AD-A had a food cart in the A-wing with individual desserts and beverages. AD-A was visiting with a resident who was in a wheelchair sitting at an even height of the desserts directly next to the food cart. The desserts were observed to be uncovered and individual plastic wrap pieces stacked up sitting next to the tray of desserts. Two staff members were observed to walk past the food cart while AD-A was visiting with the resident. AD-A confirmed the desserts were not covered and she removed the plastic wrap in the kitchen from each dessert prior to bringing the food cart down the hall as it was quicker to serve the desserts. AD-A did not perceive the desserts being uncovered as a concern. During an interview on 3/24/25 at 4:31 p.m., assistant director of nursing (ADON) stated the activities staff usually assisted in the dining room and delivered afternoon snacks. ADON was unaware of any specific training the activities staff received on handling glasses or delivering food. ADON confirmed the expectation of staff was to handle the bottom of a glass while serving	F 812	actions, including cleaning logs, temperature logs, and training attendance sheets, will be maintained and reviewed monthly by the Quality Assurance Committee and quarterly by the QAPI committee to ensure compliance. A follow-up audit will be conducted within 30 days to assess the effectiveness of corrective actions, with the Quality Assurance and QAPI committees reviewing audit results and providing further recommendations to ensure ongoing compliance		

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F 812	Continued From page 14 beverages and not touching the top rim of the glass as the glass would be contaminated with germs and a resident could become ill. ADON further confirmed desserts should be covered while the food cart goes down each hall to prevent germs from others getting on the food and potentially causing foodborne illness to the residents. ICE MACHINE During an observation on 3/23/25 at 11:37 a.m., the hot water spout on the coffee machine in the dining room had a white powder substance build up around the entire spout. In addition, the ice machine in the dining room had a white scaley substance build up around the entire inside of the spout approximately one to two inches in height. During an interview on 3/25/25 at 10:44 a.m., dietary manager (DM) verified the hot water spout on the coffee machine had a white powder substance build up around the entire spout and the ice machine had a white scaley substance build up around the entire inside of the spout. DM stated dietary staff were expected to clean the coffee machine at the end of each evening shift. DM was unaware of any staff cleaning the ice machine. DM stated there was not a log for cleaning the machines. DM verified the white substances could have bacteria present and residents could develop illness as a result. During an interview on 3/25/25 at 10:47 a.m., maintenance director stated he was unaware of cleaning logs for the coffee machine and ice machine and dietary staff were expected to clean them. The maintenance director stated he had			F 812			

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F 812	Continued From page 15 not been notified of any white substance build up on the coffee machine or the ice machine. FOOD TEMPERATURE During an observation and interview on 3/24/25 at 12:04 p.m., dietary aide (DA)-A was temping food at the steam table in the dining room. Another dietary aide was writing the food temperatures onto a piece of scratch paper. A large uncovered plastic bin of cole slaw was sitting on the counter next to the steam table. DA-A temped the cole slaw after the hot foods at 12:14 p.m., at 49.5 degrees Fahrenheit (F). DA-A starting to serve the meal and was stopped by surveyor and asked what the cold food holding temperature was supposed to be. DA-A stated she was unaware what the cold food holding temperature should be and asked the dietary manager standing behind her. DM stated the cold food holding temperature should be between 40 and 45 degrees F. DM then removed the cole slaw from the meal service. During a follow up interview on 3/24/25 at 4:10 p.m., DA-A stated temperatures were written on a piece of paper and later transferred to the three ring binder of food temp logs. The food temp logs were observed to have breakfast, noon meal and evening meal entries with the recommended temperature of each food group listed. DA-A stated she was unable to verify food temperatures without use of the log. During an interview on 3/24/25 at 4:17 p.m., DM confirmed the cole slaw was at 49.5 degrees F and was unaware cold food holding temperature was 41 degrees F or less. DM verified the food temperature logs state salad 40 to 45 degrees for	F 812			

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

PRINTED: 04/17/2025
FORM APPROVED
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F 812	Continued From page 16 cold food temperature and that dietary staff usually wrote the temperatures on a piece of paper and transfer to the log book after a meal service. DM stated there was not a policy or procedure for keeping foods cold. DM stated the expectation was dietary staff to know the proper holding food temperatures to prevent the residents from developing food borne illness. The Food and Drug Administration food code identified the danger zone refers to the range of temperatures at which bacteria can grow between 40 degrees Fahrenheit (F) and 140 degrees F. For food safety, keep food below or above the "danger zone." A facility policy titled Food Safety Requirements, undated, identified food distribution included holding foods hot on the steam table or under refrigeration for cold temperature control. When meals were assembled in the kitchen and then delivered to resident rooms, covering foods was appropriate, either individually or in a mobile food cart. Food would be covered when traveling a distance (i.e., down a hallway, to a different unit or floor). Food service safety referred to handling, preparing, and storing food in ways that prevent foodborne illness. Foodborne illness referred to an illness caused by the ingestion of contaminated food or beverages. Staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures were maintained. Staff shall refer to the current Food and Drug Administration (FDA) Food Code and facility policy for food temperatures as needed. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the	F 812			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 17 Danger Zone. A facility policy for the coffee machine was requested and not received. A facility policy titled Ice Machine Policy and Procedure reviewed 10/26/19, identified the ice machine would be washed and wiped down daily at the end of each evening shift, making sure that the storage bin drains were clear and no Lime build up had occurred. If there was lime build up to notify maintenance for descaling.	F 812			
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.	F 851			3/27/25

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F 851	Continued From page 18 §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.	F 851			

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F 851	Continued From page 19 §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and auditable data, during 1 of 1 quarters reviewed (Quarter 4), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This deficient practice had the potential to affect all 30 residents residing in the facility. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705 D identified excessively low weekend staffing. During an interview on 3/23/25 at 12:45 p.m., administrator confirmed the above findings and stated the low weekend staffing always happened because contracted staff hours had not been calculated into the system before it was submitted to CMS. Administrator further stated the PBJ would continue to be incorrect because the contracted staff hours would not be received on time from the contract company to accurately submit the facility's information to CMS.	F 851	Individual that submits the PBJ has been educated on reported issues from the Minnesota Department of Health. Minnewaska Lutheran home staff will work in conjunction with our payroll system travel agencies as well as the federal government to ensure compliant practices are occurring and accurate reports are being given through CMS. CFO/ HR will audit PBJ hours prior to submission each quarter. This will be audited prior to PBJ submission date quarterly and brought to the QAPI committee. Compliance date : next submission		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 851	Continued From page 20 During an interview on 3/25/25 at 2:22 p.m., the administrator and chief financial officer (CFO) stated contracted staff hours were gathered from the invoices the facility received from the contract company. CFO further stated the invoices were received after the required submission date of the facilities PBJ information to CMS. CFO indicated contracted staff hours would continue to not be included in the PBJ due to the dates of the invoices and the required submission time of the facility's PBJ information to CMS. Review of facility policy titled Payroll Based Journal undated, It was the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.	F 851			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880			4/15/25

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F 880	Continued From page 21 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents			F 880			

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F 880	Continued From page 22 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to establish an on-going infection control program which included comprehensive surveillance of resident infections. In addition, the facility failed to ensure hand hygiene was completed for 6 of 30 residents (R7,R10, R14, R22, R28, R31) observed during the afternoon water pitchers being delivered. These deficient practices had the potential to affect all 30 residents who resided in the facility. Findings include: SURVEILLANCE A review of the facility's infection control surveillance log titled Peerlytics dated October - December 2024 and January - March 2025, revealed the following: -Facility map included resident's room number and the resident's room was highlighted if the resident had a diagnosed infection. - The facility's current surveillance log lacked tracking necessary data which included: signs and symptoms for each infection, dates cultures			F 880	Infection Preventionists were educated by nurse consultant on importance of the surveillance, tracking and trending of infections, signs and symptoms of infections as well as antibiotic stewardship. The online infection prevention program was updated and education was completed on 4.17.2025. Nurse consultant/ administrator will audit and monitor the online infection prevention software for compliance once per week. These audits will be taken to QAA and ultimately QAPI to discuss the results and determine frequency after significant compliance is reached. Staff were educated to perform hand hygiene before and after delivering water pitchers to residents R7, R10, R14, R22, R28, and R31, and the health status of these residents was closely monitored for any signs of infection, with no adverse effects noted. A facility-wide audit of hand hygiene practices for all staff involved in resident care and service delivery was conducted, and a review of infection		

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F 880	Continued From page 23 were obtained, when the antibiotic was completed, when the antibiotic was discontinued, and when symptoms resolved. During an interview on 3/24/25 at 4:39 p.m., director of nursing (DON) and assistant director of nursing (ADON) indicated the facility used Peerlytics infection map to track resident's with diagnosed infections. DON and ADON stated the mapping document only included illnesses that were diagnosed and did not track signs and symptoms, culture results, or the antibiotic being used. HAND HYGIENE DURING WATER PITCHER PAS During an observation on 3/24/25 at 2:30 p.m., nursing assistant (NA)-B and NA-C pushed a cart of water pitchers from C-wing to A-wing. NA-B entered R7's room with a water pitcher from the cart and removed the used water pitcher from R7's room and placed on the middle shelf of the cart. NA-C entered R28's room with a water pitcher from the cart and removed the used water pitcher from R28's room and placed on the middle shelf of the cart. NA-B repeated the process for R10 and R14. NA-C repeated the process for R31 and R22. Three staff and two residents were observed to walk past the water pitcher cart. NA-B and NA-C did not sanitize their hands prior to entering a resident room or after touching the used water pitchers. During a joint interview on 3/24/25 at 2:35 p.m.,	F 880	surveillance data for all residents was initiated to identify any potential unreported infections. Weekly audits of hand hygiene practices and infection surveillance activities were implemented. The Infection Control Nurse is responsible for overseeing the implementation of corrective actions, ensuring compliance, and monitoring staff adherence to the updated hand hygiene protocols. Immediate actions were completed on 3.24.25, policy and program updates were implemented by 4.15.25, and weekly audits commenced on 4.16.25. Mandatory education on updated infection control policies and hand hygiene practices were conducted for all staff, supported by the distribution of hand hygiene educational materials to reinforce training. Audits will be brought forth to QAA/QAPI to determine frequency after 90 days.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 24 NA-B and NA-C confirmed they did not sanitize their hands during the entire water pitcher delivery service. Both NA-B and NA-C stated they should have sanitized their hands to prevent the spread of infection. During an interview on 3/24/25 at 4:31 p.m., assistant director of nursing (ADON) verified the expectation of staff would be to sanitize their hands in between the new and used water pitchers being delivered to prevent the spread of germs and possible illness to the residents. During a follow up interview on 3/24/25 at 5:36 p.m., DON and ADON confirmed the facility did not have a process for tracking and trending infections within the facility. DON and ADON further confirmed the mapping only showed current resident infections. DON and ADON indicated they were unaware all signs and symptoms needed to be tracked for every resident. DON and ADON further indicated the facility had not had an outbreak therefore there would have not been a need to track signs or symptoms for every resident. During a follow-up interview on 3/25/25 at 2:06 p.m., DON and registered nurse (RN)-A provided spreadsheets for tracking and trending of residents infections for October - December 2024 and January - March 2025. DON and RN-A stated the spreadsheets were filled out the night before. DON further stated the spreadsheets should have been used before for tracking and trending. During an interview on 3/25/25 at 2:17 p.m., administrator confirmed the above findings and indicated she was unaware tracking and trending was not being completed. Administrator stated			F 880			

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F 880	Continued From page 25 her expectations were trending and tracking of residents signs and symptoms of an infection were completed. Administrator further stated she would expect staff to completed contract tracing and utilize the facility software to help reduce/prevent an illness outbreak in the facility. Administrator indicated tracking and trending of infections was important to keep residents safe and healthy. Facility policy on infection control surveillance was requested, however one was not provided. A facility policy titled Hand Hygiene, undated, identified all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene would be performed after handling contaminated objects.	F 880			
F 912 SS=E	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the 13 single resident rooms on the A-wing had at least 100 square feet of useable floor space for 10 of 10 residents (R7, R10, R14, R16, R22, R23, R25, R27, R28, R31) who currently resided in those rooms. Findings include: During the entrance conference on 3/23/25, the	F 912	Please see letter: Leann Huseth, Unit Supervisor Minnesota Department of Health 1505 Pebble Lake Road #300 Fergus Falls, Minnesota 56537 Dear Ms. Huseth: Please accept this letter as our request to ask for a Federal waiver for the deficiency cited during our standard state survey		3/25/25

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F 912	Continued From page 26 administrator confirmed the rooms in the hallway A did not have at least 100 square feet of useable floor space as required. During the initial screening for residents on the A-wing on 3/23/25 at 12:15 p.m., the following resident rooms for R7, R10, R14, R16, R22, R23, R25, R27, R28, R31 were observed to not have at least 100 square feet of useable floor space as required. On 3/23/25 at 2:13 p.m., R14 stated she would like a bigger room when one became available but was happy with her room and had no concerns. -at 2:20 p.m., R16 rested in bed, unable to respond to a question regarding room size. -at 2:22 p.m., R25 rested in bed, unable to respond to a question regarding room size. -at 2:25 p.m., R22 stated the room was big enough for him. -at 2:40 p.m., R31 rested in bed, unable to respond to a question regarding room size. -at 2:43 p.m. R7 stated the room was big enough for her. -at 2:45 p.m., R27 stated the room was big enough for him. -at 2:50 p.m., R10 rested in bed, unable to respond to a question regarding room size. On 3/24/25 at 2:33 p.m., R23 stated the room was big enough for him.	F 912	completed by the Minnesota Department of Health and Public Safety on March 25/2025. The waiver request is in response to the following Federal Deficiency: 1. F 912 483.90 Bedrooms Measure at Least 80 SQ FT per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms A waiver has been previously reviewed and approved at the Minnesota Department of Health. A Wing rooms: 24,25,26,27,28,29,30,31,32,33,34,35 and 36 The facility recognizes that the square footage in the A wing for the private one bedrooms noted are between 95.68 to 96.07 square feet. A previous remodeling and expansion of the toileting rooms on the A wing resulted in a slightly reduced useable floor area in the rooms thus the need for a waiver. If you have any questions or concerns, please feel free to contact me. Sincerely, Mrs.Michelle M. Ehrenberg Administrator		

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F 912	Continued From page 27 -at 2:38 p.m., R28 rested in bed, unable to respond to a question regarding room size. R28's daughter stated no concerns with the room size. The following rooms on the A-wing were unoccupied A-30, A-33 and A-34. During an interview on 3/23/25 at 2:30 p.m., nursing assistant (NA)-B stated no residents had complained about the size of their rooms. During an interview on 3/24/25 at 2:35 p.m., maintenance director provided room measurements with surveyor. Maintenance director stated the rooms are less than 100 feet. During an interview on 3/25/25 at 10:13 a.m., director of nursing (DON) stated the facility would move a resident if they were not satisfied with their room. Director of nursing had not heard of any complaints about room sizes. During an interview on 3/25/25 at 10:18 a.m., administrator stated the rooms on the A-wing measured between 95.68 and 96.07 square feet. The administrator planned to apply for a waiver.	F 912			
F 919 SS=D	A facility policy was requested and not received. Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F 919			4/16/25

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

PRINTED: 04/17/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025	
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F 919	Continued From page 28 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 1 residents (R9) reviewed for call light accessibility. Findings include: R9's admission Minimum Data Set (MDS) dated 1/30/25, identified R9 was cognitively impaired and had diagnoses which included dementia, asthma, and hypertension (elevated blood pressure). Identified R9 was dependent on staff for activities of daily living (ADLs) which included bed mobility, toileting, and transfers. R9's care plan dated 1/28/25, identified R9 was at high risk for falls related to weakness, and age related osteoporosis, with an intervention dated 1/28/25, to be sure call light is within reach and encourage resident to use it for assistance as needed. During an observation on 3/23/25 at 2:00 p.m., R9 was seated in a stationary chair in her room about five ft. from her bed. R9's call light was attached to the bedrail out of R9's reach. During an observation on 3/23/25 at 2:01 p.m., on the bathroom door in R9's room was a sign that stated push call button for help. During an observation on 3/24/25 AT 8:35 A.M. R9 was seated in a stationary chair in her room about five ft. from her bed. R9's call light was			F 919	Upon identifying the deficiency, the call light for Resident R9 was repositioned immediately to ensure accessibility, with staff confirming that R9 could easily reach and use the call light. A facility-wide audit was conducted to identify any other residents with inaccessible call lights, and all identified issues were promptly corrected by repositioning call lights to ensure accessibility for all residents. Systemic changes included establishing a new protocol requiring staff to verify call light accessibility during daily rounds. Weekly audits were implemented for a three-month period to ensure compliance with call light accessibility, alongside data collection on accessibility issues, which is reviewed by the Quality Assurance Committee and quarterly by the QAPI committee to identify trends and areas for improvement. The Director of Nursing is responsible for overseeing the implementation of corrective actions, while Charge Nurses on each shift ensure compliance with the new protocols. Immediate actions were completed on 3.23.25, systemic changes were implemented on 4.16.25, and weekly audits commenced on 4.17.25. All care staff received training on the importance of call light accessibility and updated protocols during mandatory education held on 4.16.25. Detailed records of all corrective actions, audits, and training		

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F 919	Continued From page 29 attached to the bedrail out of R9's reach. During a joint interview on 3/24/25 at 8:40 a.m., nursing assistant (NA)-A and licensed practical nurse (LPN)-A verified R9's call light was attached to the bed rail and was not within reach of R9. NA-A and LPN-A verified R9 was able to use the call light. LPN-A stated her expectation was that R9's call light would be within reach. During an interview on 3/24/25 at 4:01 p.m., director of nursing (DON) verified R9 was able to use the call light. DON stated her expectations were that resident's call lights were within reach at all times so residents could call for assistance when needed. Review of a facility policy titled Call Lights: Accessibility and Timely Response revised 10/1/24, identified with each interaction in the resident's room or bathroom, staff would ensure the call light was within reach of the resident and secured, as needed.	F 919	sessions are maintained in the facility's compliance records, with documentation readily available for review during future surveys to demonstrate compliance. The Quality Assurance Committee reviews audit results monthly, and the QAPI committee reviews them quarterly to assess the effectiveness of corrective actions. Adjustments to the plan are made as necessary to ensure ongoing compliance with call light accessibility requirements.		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/23/25 to 3/25/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

04/17/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed during the survey: H55379429C (MN00111033). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000			

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum: A. the resident's legal name and preferred name; B. previous address; C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if any; I. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and clergy member; M. hospital preference; and N. name of attending physician.	2 620		3/26/25	

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2 620	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident advance directives were accurately documented in the clinical record to reflect the resident's current wishes which affected 1 of 30 residents (R9) reviewed for advanced directives. Findings include: R9's admission Minimum Data Set (MDS) dated 1/30/25, identified R9 was cognitively impaired and had diagnoses which included dementia, asthma, and hypertension (elevated blood pressure). Identified R9 was dependent on staff for activities of daily living (ADLs) which included bed mobility, toileting, and transfers. R9's current POLST signed by family member (FM)-A on 1/23/25, identified R9's wishes were DNR. The POLST was scanned into her EHR and signed by her medical provider on 1/30/25. Review of R9's current EHR Order Summary Report signed by her medical provider on 3/6/25, identified R9 had an order for CPR even though R9's POLST identified DNR. Review of R9's EHR banner on 3/23/25 at 1:12 p.m., identified R9 wanted CPR. Review of R9's face sheet in the EHR undated identified R9 was admitted to the facility on 1/24/25. Identified R9 wanted CPR. R9's care plan revised 2/6/25, identified R9 wanted CPR. Identified the POLST would be reviewed quarterly and as needed.	2 620	Corrected		

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2 620	Continued From page 4 Review of a facility report sheet dated 3/23/25 -3/29/25, located at the nurses station identified R9 wanted CPR. During an interview on 3/23/25 at 2:39 p.m., FM-A stated she had signed the POLST on 1/23/25, stating that R9's wishes were to be DNR. During an interview on 3/23/25 at 4:19 p.m., licensed practical nurse (LPN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the EHR banner and would have proceeded accordingly. LPN-A verified R9's banner identified R9 wanted CPR. LPN-A verified there was was a discrepancy between R9's banner and the POLST. During an interview on 3/23/25 at 4:22 p.m., registered nurse (RN)-A indicated in the event a resident did not have a pulse or respirations, she would refer to the report sheet located at the nurses station and would have proceeded accordingly. RN-A verified R9's report sheet identified R9 wanted CPR. RN-A verified there was a discrepancy between R9's report sheet and the POLST. During an interview on 3/23/25 at 4:24 p.m., RN-B indicated in the event a resident did not have a pulse or respirations, he would refer to the EHR banner and would have proceeded accordingly. RN-B verified R9's banner identified R9 wanted CPR. RN-B verified there was a discrepancy between R9's banner and the POLST. During a joint interview on 3/23/25 at 4:41 p.m., assistant director of nursing (ADON) and DON stated upon admission, all residents were assigned a full code (CPR) status. ADON and	2 620			

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2 620	Continued From page 5 DON stated a POLST was then completed with all residents or resident representatives and sent off to the provider for a signature. ADON and DON confirmed there was a discrepancy with R9's banner and current physician orders which identified R9 was a full code and did not match her current wishes of being DNR. ADON and DON confirmed in the event R9 did not have a pulse or respirations, CPR would have been initiated against R9's wishes. DON indicated she would expect staff to follow the POLST, resident wishes and the facility policy. Review of a facility policy titled Code Status Policy revised 5/21/21, identified the facility would follow a policy regarding a resident's right to request, refuse, and/or discontinue medical treatment and to formulate an advance directive. Identified the POLST would have been documented in the EHR. Further identified the code status would have been reviewed with Care Conferences at least quarterly and documented in the medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records are consistent and maintained accurate throughout the medical record upon admission, quarterly, and with any significant change such as the election of a hospice benefit. The DON should also ensure a process for inputting this changed data appropriately into the electronic medical record. Staff should be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee should review the resident affected, and all other current residents to ensure accuracy of code status and audit any	2 620			

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2 620	Continued From page 6 newly admitted resident EMR. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 620			
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, food was not served in a sanitary manner for 30 residents who dined in the dining area observed during dining services and who received an afternoon snack. Findings include: During an observation on 3/23/25 at 11:51 a.m., activities aide (AD)-A was serving beverages in the dining room. AD-A was not observed to wash her hands and was not wearing gloves. AD-A picked up a glass off the table holding the top rim	21000	Corrected	4/17/25	

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21000	Continued From page 7 with her fingers, poured tomato juice into the glass and placed the glass on the table. AD-A picked up another glass holding the top rim with her fingers and poured water. AD-A picked up a coffee cup holding the top rim with her fingers and carried the cup over to the hot water for tea. AD-A then placed a clothing protector around a resident's neck and touched the resident's skin while closing the snaps on the back of the clothing protector around the residents neck. AD-A proceeded to pick up a glass holding the top rim with her fingers and poured milk. AD-A picked up three prefilled thickened glasses off of the beverage cart of milk and two juices. AD-A removed the plastic wrap off of the top rim of the three glasses with her fingers, held onto the top rim and placed each glass on the table. During an interview on 3/23/25 at 12:52 p.m., AD-A stated she usually poured the beverages at lunch time. AD-A confirmed she picked up the glasses and coffee cup holding the top rim with her fingers. AD-A stated she had not received any specific training on handling glasses and did not perceive handling the top rim of the glasses as a concern. During an observation on 3/23/25 at 2:28 p.m., AD-A had a food cart in the A-wing with individual desserts and beverages. AD-A was visiting with a resident who was in a wheelchair sitting at an even height of the desserts directly next to the food cart. The desserts were observed to be uncovered and individual plastic wrap pieces stacked up sitting next to the tray of desserts. Two staff members were observed to walk past the food cart while AD-A was visiting with the resident. AD-A confirmed the desserts were not covered and she removed the plastic wrap in the kitchen from each dessert prior to bringing the	21000			

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21000	Continued From page 8 food cart down the hall as it was quicker to serve the desserts. AD-A did not perceive the desserts being uncovered as a concern. During an interview on 3/24/25 at 4:31 p.m., assistant director of nursing (ADON) stated the activities staff usually assisted in the dining room and delivered afternoon snacks. ADON was unaware of any specific training the activities staff received on handling glasses or delivering food. ADON confirmed the expectation of staff was to handle the bottom of a glass while serving beverages and not touching the top rim of the glass as the glass would be contaminated with germs and a resident could become ill. ADON further confirmed desserts should be covered while the food cart goes down each hall to prevent germs from others getting on the food and potentially causing foodborne illness to the residents. A facility policy titled Food Safety Requirements, undated, identified when meals were assembled in the kitchen and then delivered to resident rooms, covering foods was appropriate, either individually or in a mobile food cart. Food would be covered when traveling a distance (i.e., down a hallway, to a different unit or floor). Food service safety referred to handling, preparing, and storing food in ways that prevent foodborne illness. Foodborne illness referred to an illness caused by the ingestion of contaminated food or beverages. SUGGESTED METHOD OF CORRECTION: The Director Of Nursing and the Dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could	21000			

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21000	Continued From page 9 monitor the service of food on a periodic basis to ensure staff are following safe food handling practices. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21000			
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain proper holding food temperatures for cole slaw that was to be served during the evening meal for all residents in the dining room. This deficient practice had the potential to affect all 30 residents residing in the facility. Findings include: During an observation and interview on 3/24/25 at 12:04 p.m., dietary aide (DA)-A was temping food at the steam table in the dining room. Another dietary aide was writing the food temperatures onto a piece of scratch paper. A large uncovered plastic bin of cole slaw was sitting on the counter next to the steam table. DA-A temped the cole slaw after the hot foods at 12:14 p.m., at 49.5 degrees Fahrenheit (F). DA-A starting to serve	21025	Corrected	4/17/25	

Minnesota Department of Health

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21025	Continued From page 10 the meal and was stopped by surveyor and asked what the cold food holding temperature was supposed to be. DA-A stated she was unaware what the cold food holding temperature should be and asked the dietary manager standing behind her. DM stated the cold food holding temperature should be between 40 and 45 degrees F. DM then removed the cole slaw from the meal service. During a follow up interview on 3/24/25 at 4:10 p.m., DA-A stated temperatures were written on a piece of paper and later transferred to the three ring binder of food temp logs. The food temp logs were observed to have breakfast, noon meal and evening meal entries with the recommended temperature of each food group listed. DA-A stated she was unable to verify food temperatures without use of the log. During an interview on 3/24/25 at 4:17 p.m., DM confirmed the cole slaw was at 49.5 degrees F and was unaware cold food holding temperature was 41 degrees F or less. DM verified the food temperature logs state salad 40 to 45 degrees for cold food temperature and that dietary staff usually wrote the temperatures on a piece of paper and transfer to the log book after a meal service. DM stated there was not a policy or procedure for keeping foods cold. DM stated the expectation was dietary staff to know the proper holding food temperatures to prevent the residents from developing food borne illness. The Food and Drug Administration food code identified the danger zone refers to the range of temperatures at which bacteria can grow between 40 degrees Fahrenheit (F) and 140 degrees F. For food safety, keep food below or above the "danger zone."	21025			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21025	Continued From page 11 A facility policy titled Food Safety Requirements, undated, identified food distribution included holding foods hot on the steam table or under refrigeration for cold temperature control. Staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures were maintained. Staff shall refer to the current Food and Drug Administration (FDA) Food Code and facility policy for food temperatures as needed. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could could develop, review, and/or revise policies and procedures, inservice staff regarding proper holding procedures of foods for resident consumption, and audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025			
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection	21390			4/15/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21390	Continued From page 12 prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to establish an on-going infection control program which included comprehensive surveillance of resident infections. In addition, the facility failed to ensure hand hygiene was completed for 6 of 30 residents (R7,R10, R14, R22, R28, R31) observed during the afternoon water pitchers being delivered. These deficient practices had the potential to affect all 30 residents who resided in the facility. Findings include: SURVEILLANCE A review of the facility's infection control surveillance log titled Peerlytics dated October - December 2024 and January - March 2025, revealed the following:	21390	Corrected.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21390	Continued From page 13 -Facility map included resident's room number and the resident's room was highlighted if the resident had a diagnosed infection. - The facility's current surveillance log lacked tracking necessary data which included: signs and symptoms for each infection, dates cultures were obtained, when the antibiotic was completed, when the antibiotic was discontinued, and when symptoms resolved. During an interview on 3/24/25 at 4:39 p.m., director of nursing (DON) and assistant director of nursing (ADON) indicated the facility used Peerlytics infection map to track resident's with diagnosed infections. DON and ADON stated the mapping document only included illnesses that were diagnosed and did not track signs and symptoms, culture results, or the antibiotic being used. HAND HYGIENE DURING WATER PITCHER PASS During an observation on 3/24/25 at 2:30 p.m., nursing assistant (NA)-B and NA-C pushed a cart of water pitchers from C-wing to A-wing. NA-B entered R7's room with a water pitcher from the cart and removed the used water pitcher from R7's room and placed on the middle shelf of the cart. NA-C entered R28's room with a water pitcher from the cart and removed the used water pitcher from R28's room and placed on the middle shelf of the cart. NA-B repeated the process for R10 and R14. NA-C repeated the process for R31 and R22. Three staff and two residents were observed to walk past the water pitcher cart. NA-B and NA-C did not sanitize their hands prior to entering a resident room or after touching the used water pitchers.	21390			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21390	Continued From page 14 During a joint interview on 3/24/25 at 2:35 p.m., NA-B and NA-C confirmed they did not sanitize their hands during the entire water pitcher delivery service. Both NA-B and NA-C stated they should have sanitized their hands to prevent the spread of infection. During an interview on 3/24/25 at 4:31 p.m., ADON verified the expectation of staff would be to sanitize their hands in between the new and used water pitchers being delivered to prevent the spread of germs and possible illness to the residents. During a follow up interview on 3/24/25 at 5:36 p.m., DON and ADON confirmed the facility did not have a process for tracking and trending infections within the facility. DON and ADON further confirmed the mapping only showed current resident infections. DON and ADON indicated they were unaware all signs and symptoms needed to be tracked for every resident. DON and ADON further indicated the facility had not had an outbreak therefore there would have not been a need to track signs or symptoms for every resident. During a follow-up interview on 3/25/25 at 2:06 p.m., DON and registered nurse (RN)-A provided spreadsheets for tracking and trending of residents infections for October - December 2024 and January - March 2025. DON and RN-A stated the spreadsheets were filled out the night before. DON further stated the spreadsheets should have been used before for tracking and trending. During an interview on 3/25/25 at 2:17 p.m., administrator confirmed the above findings and indicated she was unaware tracking and trending	21390			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21390	Continued From page 15 was not being completed. Administrator stated her expectations were trending and tracking of residents signs and symptoms of an infection were completed. Administrator further stated she would expect staff to completed contract tracing and utilize the facility software to help reduce/prevent an illness outbreak in the facility. Administrator indicated tracking and trending of infections was important to keep residents safe and healthy. Facility policy on infection control surveillance was requested, however one was not provided. A facility policy titled Hand Hygiene, undated, identified all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene would be performed after handling contaminated objects. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies and procedures to ensure resident infections with specific organisms were tracked, and analyzed for any patterns or trends in the facility. In addition, the director of nursing or designee could review policies and procedures on hand hygiene. Facility staff could be re-educated and an auditing system developed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390			
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant,	21685			3/25/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21685	Continued From page 16 including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 7 of 10 resident rooms (101, 104,107, 116, A-25, A-29, A-35), tested for safe water temperatures. This deficient practice had the potential to affect all 7 residents who used water from the water faucets in the affected area. Findings include: On 3/23/25 at 2:00 p.m., during resident screening the water temperatures in rooms 101 104, 107 and 116, felt very warm to the touch after running water for one minute. During an observation and interview on 3/24/25 at 8:50 a.m., maintenance director (MD) used the facility digital thermometer to measure the water temperatures in resident rooms. MD verified the water temperatures were above 115 degrees Fahrenheit (F) and resident hot water temperatures were to be maintained between 105- and 115-degrees F. DM stated the facility got a new boiler and hot water heater last fall. Water temperatures were as follows: -room 101-119.2 degrees F.	21685	Corrected.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21685	Continued From page 17 -room 104-118 degrees F. -room 107-119 degrees F. -room 116-117.6 degrees F. -room A-25 -117 degrees F. -room A29 117.4 degrees F. -room A35-117.4 degrees F. During an interview on 3/24/25 at 11:00 a.m., nursing assistant (NA)-A indicated multiple residents were able to access their hot water, and some of those residents were cognitively impaired. During an interview on 3/24/25 at 10:50 a.m., registered nurse (RN)-A verified multiple residents were able to access their hot water, and some of those residents were cognitively impaired. During an interview on 3/24/25 at 4:05 p.m., administrator indicated her expectation was the facility policy and state and federal guidelines for water temperatures would have been followed. Review of a facility policy titled Safe Water Temperatures undated, identified water temperatures would be set to a temperature of no more than 115 degrees F, or the state's allowable maximum water temperature. Identified maintenance would have checked the water heater temperature controls and temperatures of tap water in all hot water circuits weekly and as needed. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure hot water temperatures do not exceed 115 degrees for resident use, and a preventative maintenance program was developed to accurately reflect ongoing	21685			

Minnesota Department of Health

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21685	Continued From page 18 preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685			
21720	MN Rule 4658.1415 Subp. 9 Plant Housekeeping, Operation, & Maintenance Subp. 9. Storage of supplies. Supplies must be stored above the floor to facilitate cleaning of the storage area. Supplies must be identified. Toxic substances must be clearly identified and stored in a locked enclosure. Sterile supplies must be stored to maintain sterility and integrity in packaging. All substances, such as cleaning agents, bleaches, detergents, disinfectants, pesticides, paints, and flammable liquids, must be stored separately from all food and drugs. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cleaning chemicals were secured away in a locked cabinet or cart, which had the potential to affect all residents residing on the B-wing (8 rooms - B-39, B-40, B-41, B-42, B-43, B-44, B-45, B-46). Additionally, it had the potential to affect 2 of 30 (R22 and R10) who were observed walking down	21720	Corrected		4/15/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21720	Continued From page 19 the hallway. Findings include: R22's quarterly Minimum Data Set (MDS) dated 1/3/25, identified R22 was severely cognitively impaired and had diagnoses which included dementia, traumatic brain injury (TBI) and alcohol dependence. Identified R22 was independent with transfers and mobility. R22's care plan revised 3/23/25, identified R22 had wandering behaviors. R10's annual Minimum Data Set (MDS) dated 2/14/25, identified R10 was severely cognitively impaired and had diagnoses which included dementia, depression, and glaucoma (difficulty with vision). Identified R10 was independent with transfers and mobility. R10's care plan revised 3/6/25, identified R10 had wandering behaviors. During observations the following was observed: -3/23/25 at 11:45 a.m., the tub/shower room door was propped open with the white trash can. Sitting to the right of the tub on the floor were two full bottles of vindicator+ (disinfectant/cleaner) one with no cap and the other closed with a cap. Sitting on the green rolling cart with hygiene supplies was one bottle of QT-TB (disinfectant/cleaner) 3/4 full in a spray bottle. Sitting on the tan rolling cart with hygiene supplies was a one bottle of Quarternary (Barrier II) based sanitizer 3/4 full in a spray bottle. The storage room B-50's door was open and one full bottle of pine liquid odor control was sitting on the floor in front of the wooden toiletry shelf. No staff were	21720			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21720	Continued From page 20 present down the hallway or ar the nurses' station. -3/23/25 at 2:10 p.m., both doors remained open and chemicals remained in the same place. -3/24/25 at 8:38 a.m., tub/shower room door continued to be propped open with the white trash can. Sitting to the right of the tub on the floor was one full bottle of vindicator+ and one empty bottle. Sitting on the white wire shelf above the tan rolling care was one bottle of QT-TB 3/4 full. The storage room B-50's door was open and one full bottle of pine liquid odor control was sitting on the floor in front of the wooden toiletry shelf. No staff were present down the hallway or ar the nurses station. -3/24/25 at 11:11 a.m., both doors remained open and chemicals remained in the same place. R22 walked down the hallway past both open doors to the exit. R22 remained at the exit door for approximately two minutes and walked back down the hallway past both open doors to another part of the facility. -3/24/25 at 1:39 p.m., both doors remained open and chemicals remained in the same place. -3/24/25 at 1:48 p.m., both doors remained open and chemicals remained in the same place. Nursing staff left the B-wing. - 3/25/25 at 7:25 a.m., tub/shower room door continued to be propped open with the white trash can. Sitting to the right of the tub on the floor was one full bottle of vindicator+ and one empty bottle. Sitting on the white wire shelf above the tan rolling care was one bottle of QT-TB 3/4 full. The storage room B-50's door was open and one full	21720			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21720	Continued From page 21 bottle of pine liquid odor control was sitting on the floor in front of the wooden toiletry shelf. No staff were present down the hallway or at the nurses station. -3/25/25 at 12:56 p.m., both doors remained open and chemicals remained in the same place. R10 wheeled in R10's wheelchair down the hallway past both open doors to the exit door. R10 remained at the exit door for approximately five minutes. R10 wheeled R10's wheelchair back down the hallway past both open doors to another area in the facility. -3/25/25 at 1:12 p.m., both doors remained open and chemicals remained in the same place. R22 walked down the hallway past both open doors to the exit. R22 remained at the exit door for approximately two minutes and walked back down the hallway past both open doors to another part of the facility. During an interview on 3/25/25 at 1:20 p.m., nursing assistant (NA)-A stated nursing staff cleaned and disinfected the tub after a resident had received a bath and before another resident would enter the tub. NA-A indicated both doors were to be shut after staff were finished cleaning and disinfecting the tub or getting supplies out of the storage area. When NA-A was finished talking with surveyor, NA-A left the B-wing and both doors remained open. During an interview on 3/25/25 at 1:55 p.m., director of nursing (DON) confirmed the above findings and stated the doors to both rooms were to be closed at all times. DON indicated neither room had a lock on the door and chemicals were not locked in a storage area. DON further indicated even if the doors were closed the	21720			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21720	Continued From page 22 chemicals would not be stored properly. DON stated having chemicals sitting out could have the potential for a harmful situation. During an interview on 3/25/25 at 2:14 p.m. administrator confirmed the above findings and stated her expectations were chemicals were to be locked up and both doors were to be closed. The Hillyard material safety data sheet (MSDS) for Vindicator+ revised 2/4/21, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. The Hillyard MSDS for QT-TB revised 8/12/21, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. The Anderson Chemical Company MSDS for Barrier II revised 4/9/20, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. The Genlabs MSDS for Pine Odor Control revised 11/4/20, indicated the disinfectant/cleaner was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to	21720			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/25/2025
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21720	Continued From page 23 seek immediate medical attention if ingestion or eye or skin contact occurred. Facility policy titled Hazard Communication and Employee Right-to-Know dated 9/23, was to educate the employees of the hazardous substances, physical and infectious agents that may endanger their health and well-being while at work. Chemicals, through the different steps from their production to their handling, transport and use, may be a real danger for human health and the environment. People of any ages, from children to elderly, using many different languages and alphabets, belonging to various social conditions, including illiterates, were daily confronted to dangerous products (chemicals, pesticides, etc.) SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or designee could ensure safe storage of chemicals was maintained and inspection program was developed, scheduled and audited. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21720			

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

PRINTED: 04/17/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 01 - 1960 BUILDING AND ADDITIONS B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025	
NAME OF PROVIDER OR SUPPLIER MINNEWASKA COMMUNITY HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET STARBUCK, MN 56381			
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/27/2025. At the time of this survey, Minnewaska Community Health Services was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/17/2025

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

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NAME OF PROVIDER OR SUPPLIER MINNEWASKA COMMUNITY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET STARBUCK, MN 56381		
(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 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Minnewaska Community Health Services is a one-story building with no basement originally constructed in 1960 and additions built in 1968, 1972, and 2000. The original building and three additions were built of Type II(111) construction. Two other additions were built in 1988 and 1996 that were determined to be Type V(111) construction. Since both construction types conform to a building of this height, Minnewaska Community Health Services will be surveyed as one building of the least protected construction	K 000			

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K 000	Continued From page 2 type. The facility is divided into five separate smoke compartments. The facility is fully protected throughout by an automatic fire sprinkler system. In addition, the facility has a fire alarm system with smoke detection in the egress corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 39 beds and had a census of 30 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the level of exit discharge per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7 , 7.7.1, and 7.1.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/27/2025 between 9:30 AM and 12:30 PM,			K 271	A third party was contacted to provide the concrete work outside of the emergency exit on 4/15/2025. Will monitor progress.		4/15/25

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DGX721 Facility ID: 00477 If continuation sheet Page 4 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 01 - 1960 BUILDING AND ADDITIONS B. WING _____		(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER MINNEWASKA COMMUNITY HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET STARBUCK, MN 56381		
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K 321	Continued From page 4 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.6.3.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 03/27/2025 between 9:30 AM and 12:30 PM, it was revealed by observation that the door for Storage Room A22 did not positively latch when closed. 2. On 03/27/2025 between 9:30 AM and 12:30 PM, it was revealed by observation that the fire door to the Dietary Storage room was blocked open with a door wedge. Violation was corrected at the time of discovery. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	Doors were repaired 3.27.2025. Monitoring efforts include scheduling twice weekly audits of doors. For 90 days starting 4.15.25, as well as reviewing the tracking system for maintenance requests and repairs, with the safety committee overseeing audit results and addressing recurring issues. Immediate corrective actions were completed on 3.27.25, and audits began biweekly on 4.15.25. Staff have been trained that no door should be propped open.		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core	K 363		3/27/25	

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K 363	Continued From page 5 wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1, and 19.3.6.3.5. This deficient finding could have an isolated impact on the residents	K 363	Doors were repaired 3.27.2025. Monitoring efforts include scheduling twice weekly audits of doors. For 90 days starting 4.15.25, as well as reviewing the tracking system for maintenance requests		

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K 363	Continued From page 6 within the facility. Findings include: On 03/27/2025 between 9:30 AM and 12:30 PM, it was revealed by observation that the door for resident Room A25 did not latch when it was closed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	and repairs, with the safety committee overseeing audit results and addressing recurring issues. Immediate corrective actions were completed on 3.27.25, and audits began biweekly on 4.15.25. Staff have been trained that no door should be propped open. Audits will be brought to QAPI to determine frequency.		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 712	Fire drills have been placed in the Preventative Maintenance program to be done at different times, different shifts and recorded on the fire drill logs and fire drill matrix in the preventative maintenance program. The facility has reached full compliance as of 03/30/2025. Assistant administrator will audit every 30 days for a quarter, bring audits to QAPI to determine	3/30/25	

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K 712	Continued From page 7 On 03/27/2025 between 9:30 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the third shift of the 4th quarter of 2024. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	frequency.		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245537	MULTIPLE CONSTRUCTION A. BUILDING: 01 - 01 - 1960 BUILDING AND ADDITIONS B. WING _____	DATE SURVEY COMPLETE: 3/27/2025
NAME OF PROVIDER OR SUPPLIER MINNEWASKA COMMUNITY HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET STARBUCK, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 03/27/2025 between 9:30 AM and 12:30 PM, it was revealed by observation that sprinkler heads in the Laundry Area were covered in lint and debris. Violation was corrected at the time of discovery. An interview with Maintenance Director verified this deficient finding at the time of discovery.			

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The above isolated deficiencies pose no actual harm to the residents

031099

Event ID: DGX721

If continuation sheet 1 of 1