Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 3, 2025

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: CCN: 245319
Cycle Start Date: February 6, 2025

Dear Administrator:

On March 21, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
February 26, 2025

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: CCN: 245319
Cycle Start Date: February 6, 2025

Dear Administrator:

On February 6, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 6, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 6, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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 2/3/25 to 2/6/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was 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 2/3/25-2/6/25, 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 following complaints were reviewed with NO deficiencies cited: H53196623C (MN00109543) and H53196622C (MN00104561) and H53196624C (MN00106527). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 03/06/2025

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 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: Based on observation, interview, and document review, the facility failed to ensure refrigerated food items were disposed of after expiration date and were properly stored, labeled and dated. This had the potential to affect 28 of 28 residents, staff and visitors who may eat from the facility kitchen. Findings include: During an initial tour of the kitchen on 2/3/25 at approximately 1:51 p.m., while verifying temperatures of the refrigerators, it was identified a box of oranges dated 12/31/24 with what looked like some white fuzz on one of the oranges and brown liquid coming from a bag of grapes.	F 812	No specific resident identified. In-house residents, visitors, and staff receiving nourishment have the potential to be impacted by this practice. Dietary Manager, or designee, will re-educate facility staff regarding safe food items storage policy and procedure. Laminated signs have been posted on Kitchen Refrigerators/Freezers stating "Only Resident Use Items Allowed. No Staff Items Allowed. Please use the break room for storage of personal items." The Executive Director, or designee, will audit dietary and resident food storage	3/18/25

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F 812	Continued From page 2 During a follow up observation and interview on 2/5/25 at 11:30 a.m., dietary aide (DA)-B identified a half gallon of expired milk with an expiration date of 1/27/25 on the front of the container and a can of soda and opened bottle of water next to the milk. DA-B was unaware what the half gallon of skim milk was used for and why the soda was in the refrigerator. DA-B indicated this was one of the main refrigerators used to store the prepared foods served to the residents. During an interview on 2/5/25 at 12:00 p.m., interim dietary manager (IDM) who overlooks several facilities and dietary staff. IDM reviewed the policy for labeling foods and there should be nothing used after expired. The IDM was informed there was some personal items such as a soda and a used water bottle in the refrigerator next to some of the food that is used to prepare the food for the residents. During an initial phone interview on 2/05/25 at 2:35 p.m., registered dietician (RD) visits the facility monthly or as needed. During a follow up visit to the kitchen on 2/06/25 at 8:52 a.m., the half-gallon of skim milk remained in the refrigerator, unsure if it was used. During an interview on 2/06/25 at 8:53 a.m., DA-A explained the date on the half gallon skim milk was received from the food vendor on 1/21/2025 and opened on 2/3/2025. DA-A explained the dietary staff take turns going through the refrigerators and checking for items that were outdated or maybe expired. DA-A verified the expired date on the milk read 1/27/2025, and DA-A was not aware of what they were using the expired milk for or who had	F 812	refrigerators and/or freezers for proper storage of food items twice weekly for six weeks and then monthly to monitor until substantial compliance is maintained. Executive Director, or designee, will present findings to QAPI for review and recommendation. Facility will be compliant by 03/18/2025.	

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F 812	Continued From page 3 opened the milk. DA-A took the milk out of the refrigerator and discarded the milk in the sink. DA-A said the milk should not be served to residents because there is a chance of the residents getting sick. DA-A would expect the staff to discard any items expired and notify the dietary manager. DA-A was unable to verify who the soda belonged to, which remained in the refrigerator. DA-A confirmed the orange covered in white fuzzy substance. DA-A was unsure what to do with the other oranges. DA-A explained they would take them out of the refrigerator and reach out to the IDM for further steps. All temperatures were with in normal limits for the refrigerators and DA-A was unaware of any issues with the refrigerator. During a follow up phone call on 2/06/25 at 09:17 a.m., RD said there is a monthly audit completed and is used for all of the refrigerators. RD said the sanitation audit is done anytime during the month, however it is usually completed with in the first 15 days of the month. During the audit any expired or moldy items would be pulled and a conversation would occur with the cook on replacement of the items. RD added if an item was opened and found to be expired, a notification to the DON infection preventionist would be included to protect residents from being exposed to food borne illness. During an interview on 2/06/25 at 9:34 a.m., administrator explained they have been working with the Healthcare Services Group for their dietary needs for several years. The expectation is any contracted staff would be familiar with the requirements and are informed on all current procedures and policies pertaining to the dietary needs of the residents.	F 812		

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F 812	Continued From page 4 During an interview on 2/06/25 on 9:45 a.m., director of nursing (DON) and IDM stated when informed about the food contamination they would follow the process like any other infection control process. The facility would audit the kitchen, staff, and residents for follow up concerns, The dietary staff are trained on how to handle food items and expectations are outlined prior to hiring. All staff are required to report any type of concern to the DON, IDM, and/ or nursing staff. The staff are also suppose to store their personal food items in the breakroom and not anywhere in the kitchen. Facility policy titled Food Storage, dated 8/16/22, includes Sufficient storage facilities provided to keep foods safe, wholesome and appetizing. Food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored at all temperatures and by methods designed to prevent contamination or cross contamination. All stock rotation with each new order received includes old stock rotated used first, food should be dated as it is place on to shelves, date marking will be visible on all high-risk foods to indicate when opened and discarded. Facility Healthcare services agreement includes: Track weekly food items, purchase, store, and handle food properly.	F 812		
F 880 SS=D	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	F 880		3/18/25

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F 880	Continued From page 5 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

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F 880	Continued From page 6 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper use of personal protective equipment (PPE) during cares for 1 of 3 residents (R14) reviewed for enhanced barrier precautions (EBP). Findings include: R14's quarterly Minimum Data Set (MDS) dated 12/18/24, indicated R14 was cognitively intact and had surgical repair of deep ulcers. R14's provider orders included enhanced barrier precautions d/t surgical wound to left ankle. R14's diagnoses list included osteomyelitis (bone	F 880	Identified Nursing Assistants were re-educated on Enhanced Barrier precautions by Director of Nursing or designee on 02/05/2025. Resident 14 remains in-house and is assisted by facility staff. In-house residents have the potential to be impacted by this practice. Director of Nursing, or designee, will re-educate facility staff regarding enhanced barrier precautions policy and procedure. Enhanced Barrier precautions policy and procedure with quiz was added to agency staff orientation packet.	

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F 880	Continued From page 7 infection) to ankle and foot. R14's care plan indicated history of streptococcal arthritis (type of infection) to left ankle and foot, surgical incision and deep tissue injury to left foot, and EBP related to surgical wound to left ankle. During an observation and interview on 2/3/25 at 2:57 p.m., an orange sign indicating EBP was posted on the door outside R14's room. A shelving unit containing gowns and gloves was located across the hall outside another resident's room. A second cart containing PPE was located further down the hall near the hand washing station. A second sign was posted inside R14's room next to an over-the-door shelving unit containing gloves. During the interview, R14 stated staff wear the gowns when changing her bandages on her foot however no other time. R14 stated staff wore the gowns for "safety". During an observation on 2/5/24 at 3:23 p.m., nursing assistant (NA)-A and NA-B entered R14's room with the mechanically stand (machine used to assist with transferring residents) to ready R14 for a shower. NA-A and NA-B were not wearing a gown or gloves. NA-A assisted R14 with putting on gripper socks and placed stand sling under R14's arms. NA-A applied gloves from the shelving unit on R14's door. NA-B operated stand assisting R14 to standing position. NA-A pulled down R14's incontinence brief and placed the shower chair behind R14. NA-B then lowered R14 to the shower chair and left the room with the stand. While still wearing gloves, NA-A removed R14's incontinence brief, threw it away, removed gloves and washed her hands. R14 grabbed the items needed for the shower while NA-A draped a sheet around R14's shoulders and lap for privacy.	F 880	Enhanced barrier precautions education will be scheduled yearly in Relias for direct care staff. In addition to the sign that is already posted on the outside of the resident's room, enhanced barrier precautions signs will be added to the inside of residents' room to alert staff that they need to use enhanced barrier precautions. The Director of Nursing, or designee, will complete audits to ensure that staff are using proper enhanced barrier precaution procedures per policy twice weekly for six weeks and then monthly to monitor until substantial compliance is maintained. Director of Nursing, or designee, will present audit findings to QAPI for review and recommendation. Facility will be compliant by 03/18/2025.	

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F 880	Continued From page 8 NA-A brought R14 to the shower room located down the hall. In the shower room, NA-A washed hands and applied gloves however, did not don (put on) a gown. R14 removed own night gown while NA-A removed R14's socks. NA-A removed the wrap around R14's left foot and wheeled resident into shower area. R14 was able to wash chest, arms, abdomen, and legs independently. NA-A washed R14's hair and back while wearing gloves but no gown. After the shower, R14 was able to dry her head, chest, arms, abdomen, and upper legs independently. NA-A dried R14's back and lower legs. R14 put on night gown independently. NA-A put gripper socks on R14's feet and draped her with a sheet for privacy and exited shower room. Outside R14's room the director of nursing (DON) and registered nurse (RN)-A were donning gloves and isolation gown in preparation to assess and apply dressing to R14's surgical wound. After wheeling R14 into the room, NA-A put on gloves and isolation gown. NA-A and RN-A assisted R14 into bed. NA-A removed PPE and left the room. During an interview on 2/5/25 at 4:18 p.m., NA-A stated she was employed with a staffing agency and it was her 3rd day at the facility. NA-A stated PPE should be worn upon entering a resident's room who was on precautions. The type of PPE used was dependent on the type of precaution. If a resident has a wound, PPE should be worn for all cares. NA-A stated she did not know R14 had a wound but did confirm PPE should have been worn during R14's shower. During an interview on 2/5/25 at 4:22 p.m., NA-B stated staff are informed verbally when residents are placed on precautions and have had training's regarding why resident's are placed on	F 880		

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	245319	A. BUILDING _____ B. WING _____	C 02/06/2025

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F 880	Continued From page 9 precautions. NA-B stated when residents are on precautions, staff should wear a gown and gloves for all cares. NA-B reported seeing the EBP sign outside R14's room however the cart with PPE was down the hall outside another resident's room. NA-B stated the cart should have been outside R14's room. During an interview on 2/6/25 at 8:35 a.m., the DON stated a sign is placed on the door of a resident's room indicating a resident is placed on precautions. Staff are instructed to follow a resident's care plan and the signs outside a resident's door. The sign on the doors indicate what activities require the use of PPE and what PPE to be used. Further, the DON indicated PPE should be worn for bathing, hygiene, transfers, and changing linens for residents on EBP. A policy revised 8/8/24 titled "Enhanced Barrier Precautions" indicated the policy is in place to prevent the transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions is defined as "an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities". ...gowns and gloves should be made available immediately near or outside the resident's room..... high-contact resident care activities as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care of any chronic skin opening requiring a dressing..... enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room.	F 880		

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	245319	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/05/2025**

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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 02/05/2025. At the time of this survey, LA CRESCENT 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		03/06/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. LA CRESCENT HEALTH SERVICES is a 1 story building with no basement. The original building was constructed in 1968, one-story with no basement, and was determined to be of Type II (000) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and	K 000		

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K 000	Continued From page 2 spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced	K 324		2/12/25

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K 324	Continued From page 3 by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 02/05/2025 between 9:30 AM and 1:00 PM, it was revealed by observation that the residential stove-range located in the PT / OT Activities Area was outfitted with a 120 min max timeout, but no means was observed or demonstrated that the timer unit was able to be locked out. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	Maintenance Director, or designee, installed proper timer locking device per safety guidelines on 02/12/2025. Maintenance Director checked for similar equipment throughout the facility and none was found. Maintenance Director will be responsible for future compliance. Facility is compliant as of 02/12/2025.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the fire alarm system per NFPA 101 (2012 edition), Life	K 345	Maintenance Director was re-educated by Executive Director regarding policy and procedure regarding fire alarm system	3/18/25

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K 345	Continued From page 4 Safety Code, sections 19.7.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/05/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation, that documentation present for review did not confirm that signal transmission of a fire alarm system occurred: 1st Shift - Q1; 3rd Shift - Q1 through Q4. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	testing. Executive Director, or designee, will audit fire system testing documentation once weekly for six weeks or until substantial compliance is maintained. Facility will be compliant on 03/18/2025.	
K 712 SS=F	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 document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 19.7.1. These deficient findings could have a widespread	K 712	The Maintenance Director was re-educated by Executive Director regarding policy and procedure regarding fire drills. Executive Director, or designee, will audit fire drill documentation once	3/18/25

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K 712	Continued From page 5 impact on the residents within the facility. Findings include: On 02/05/2025 between 9:30 AM and 1:00 PM, it was revealed by a review of available documentation, that no documentation was available or presented to confirm that fire drills were conducted: 1st Shift - Q1; 3rd Shift - Q1 through Q4. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 712	weekly for six weeks or until substantial compliance is maintained. Facility will be compliant on 03/18/2025.	
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.	K 741		3/18/25

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K 741	Continued From page 6 (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the facility smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/05/2025 between 9:30 AM and 1:00 PM, it was revealed by a review of available documentation that the smoking policy was generic in content, not providing if smoking was allowed on-campus, and if allowed, the identified and approved locations for staff, residents, visitors to smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	Executive Director, or designee, reviewed and established smoking policy to ensure reflection of designated smoking areas. Maintenance Director, or designee, will implement signage to alert that the facility is a non-smoking campus and that individuals must smoke off campus. The Executive Director, or designee, will re-educate staff regarding smoking policy and procedure and designated smoking areas. Executive Director, or designee, will audit for proper implementation of the smoking policy and procedure two times weekly for six weeks or until substantial compliance is maintained. Facility will be compliant on 03/18/2025.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not	K 914		2/20/25

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K 914	Continued From page 7 listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based a review of available documentation and staff interview, the facility failed engage corrective action(s) associated to electrical receptacle(s) in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/05/2025 between 9:30 AM and 1:00 PM, it was revealed by review of available documentation that electrical outlet testing was last completed in 04/23/2024. No corrective actions were noted for failed devices and no documentation was presented to confirm that repairs had been completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	Maintenance Director was re-educated by Executive Director regarding receptacle testing, replacement, and documentation. Maintenance Director performed receptacle testing and documented results on 02/11/2025. Graff Electric replaced faulty receptacles on 02/20/2025. The Executive Director confirmed that documentation is present for both events. Maintenance Director will be responsible for future compliance. Facility is compliant as of 02/20/2025.	

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