Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 30, 2024

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

RE: CCN: 245490
Cycle Start Date: December 13, 2023

Dear Administrator:

On January 23, 2024, the Minnesota Department(s) 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 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
January 30, 2024

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

Re: Reinspection Results
Event ID: EHHV12

Dear Administrator:

On January 23, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 13, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2023

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

RE: CCN: 245490
Cycle Start Date: December 13, 2023

Dear Administrator:

On December 13, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 13, 2024 (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 June 13, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
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
Phone: 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
	245490	A. BUILDING _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

(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 12/11/23-12/13/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 12/11/23-12/13/23, 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: H54907717C (MN00098336) H54907718C (MN00098942) H54907719C (MN00086218) 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 | 01/05/2024

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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a jacket was offered and/or provided for a resident who rode a bus to an appointment for 1 of 1 resident (R74) reviewed for activities of daily living (ADL) . Findings include: R74's quarterly Minimum Data Set (MDS) assessment dated 8/31/23, indicated intact cognition, no rejection of cares, required one person physical assistance for bed mobility, transfers, ambulation in the room, dressing, toileting, and hygiene, utilized a walker and wheelchair, diagnoses included fracture of the lower end of right radius (long bone of the forearm), muscle wasting, pain in right wrist, muscle weakness, and need for assistance with personal care. R74's care plan dated 9/29/23, indicated ADL: altered self-care performance, limited physical mobility R/T (related/to) fracture, pain, weakness, and interventions included dressing: resident requires 1 person limited physical assist with dressing skills. On 12/11/23 at 2:17 p.m., R74 stated today (12/11/23), after lunch she was returning to her room via her wheelchair, and was stopped by a staff member. R74 stated she was told she had a	F 677	F677 SS=D ADL Care Provided for Dependent Residents Corrective Action: Deskside in-service has been provided to educate all staff to ensure that residents are properly dressed for outside appointments. All new direct care staff will be informed on proper clothing attire related to weather elements for outside appointments on the orientation checklist. A sign has been placed in R74 room to ask the resident what she would like to wear to her appointment, ensuring that she is being offered the correct clothing attire related to weather elements for outside appointments. This will also be added to R74's care plan. When the HUC prints out the Mobility Passport tag for resident appointments, the HUC will add a box reminding the staff to ask the residents what type of clothing attire they would like to wear according to the weather elements. Audits will be completed on proper clothing attire related to weather elements. Audits will be completed on 3 residents monthly x 3 months. Report	1/12/24

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F 677	Continued From page 2 doctor appointment, and staff pushed her in her wheelchair and placed her outside on the bus that provided transportation. R74 stated staff put her on the bus, "just like this with no coat, jacket, and got on the bus". R74 was dressed with long pants, a long sleeve shirt, sweater, socks and shoes. R74 stated she was not warm on the bus ride, and further stated she rode the bus to and from her doctor's appointment with no coat, and stated the bus ride was about five to ten minutes each way. R74 stated staff did not offer her a coat, and stated she would have worn a coat if offered. On 12/12/23 at 9:03 a.m., nursing assistant (NA)-A confirmed yesterday she assisted R74 from lunch via her wheelchair to the bus outside, and stated R74 had a doctor's appointment. NA-A confirmed R74 was not offered or provided a jacket when she went outside, and confirmed she should have offered R74 a coat with the colder weather. On 12/12/23 at 9:23 a.m., registered nurse (RN)-A, who was the case manager for R74, stated she would expect staff to have asked R74 if she wanted a coat when going outside and riding the bus to the doctor's appointment. On 12/12/23 at 9:27 a.m., during a follow up interview R74 confirmed she wanted a coat when she went outside and rode the bus yesterday. On 12/12/23 at 3:30 p.m., the director of nursing stated she would have expected staff to offer R74 a coat prior to assisting R74 outside for the bus ride to the doctor's appointment. On 12/11/23, Accuweather indicated the weather	F 677	audits results to QAPI. Actual/proposed completion date: 1/12/2023 Person Responsible for correction/monitoring: Director of Nursing, Administrator, Assisted Director of Nursing.	

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F 677	Continued From page 3 was high of 41 degrees Fahrenheit, and low of 18 degrees Fahrenheit. The facility Activities of Daily Living (ADLs), Supporting policy dated 11/21/23, indicated: Policy Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care);	F 677		
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	F 880		1/12/24

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F 880	Continued From page 4 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 §483.70(e) 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.	F 880		

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F 880	Continued From page 5 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a water management program consistent with nationally accepted standards, e.g., ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) or CDC (Centers for Disease Control and Prevention). This had the potential to effect all 83 residents who resided in the facility. Findings included: During an interview on 12/13/23 at 9:53 a.m., maintenance worker (MW)-A stated he was responsible for the facility water management program. MW-A explained the actions he took related to the water management program which included testing water for chlorine levels, measuring water temperatures at various sites in the facility, and running water in vacant resident rooms. MW-A was not aware of additional requirements of an effective water management program including completion of a Legionella risk assessment, creating a detailed diagram of the facility water system and following a nationally	F 880	F880 SS=F Infection Prevention & Control Corrective Action: We completed the CDC risk assessment and set up a Water Management Team which includes the Environmental Service Director, Maintenance Director, Maintenance Assistant, Director of Nursing, Infection Control Nurse, Administrator and Medical Director. The Water Management Team will meet on a quarterly basis and as needed. Maintenance will be reporting on temps, soft water, and chlorine levels. On an annual basis, the Water Management Team will reevaulate the Water Management Program. Actual/proposed completion date: 1/12/2024 Person responsible for correction/monitoring: Maintenance Director, Maintenance Assistant, Infection	

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F 880	Continued From page 6 accepted water management program. During an interview on 12/13/23 at 10:05 a.m., findings were explained to the director of nursing (DON) and registered nurse (RN)-B, who was also the infection preventionist. The DON stated they had a document from ASHRAE titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, but had not yet implemented the standards outlined in that document. RN-B confirmed there had been no cases of Legionnaires disease in the facility. Facility Legionella Water Management Program policy, reviewed on 7/13/20, indicated as part of the infection prevention and control program, the facility had a water management program. The purpose of the program was to identify areas in the water system where Legionella bacteria could grow and spread, and to reduce the risk of Legionnaire's disease. The water management program would be based upon CDC and ASHRAE recommendations for developing a Legionella water management program. The program would have a detailed description and diagram of the water system into the facility, including receiving, cold water distribution, heating, hot water distribution, and waste. Specific measures would be used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants) and a system to monitor control limits and the effectiveness of control measures. Although the facility water management program policy identified the appropriate measures for an effective water management program, not all of the measures had been implemented, such as a	F 880	Control Nurse, Administrator.	

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F 880	Continued From page 7 risk assessment to determine vulnerabilities for Legionella, creation of a detailed description and diagram of the water system into the facility, and specific measures to monitor control limits.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH** **NEW ULM, MN 56073**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/12/2023. At the time of this survey, Oak Hills Living Center 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		01/05/2024

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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	245490	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH** **NEW ULM, MN 56073**

(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. OAK HILLS LIVING CENTER is a 2 story building with no basement. The original building was constructed in 1995, two-story with no basement, and was determined to be of Type II (111) construction. In 2009 an addition was constructed, two-story with no basement, and was determined to be of Type II(111) construction. Because the original building and the addition are	K 000		

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K 000	Continued From page 2 compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 94 beds and had a census of 83 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=E	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.	K 324		12/12/23

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K 324	Continued From page 3 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire suppression system in the kitchen per NFPA 101 (2012 edition), Life Safety Code, sections19.3.2.5.1 through 19.3.2.5.5 and 9.2.3. This deficient finding could have a pattered impact on the residents within the facility. Findings include: On 12/12/2023 at 9:30AM, it was revealed by a review of available documentation kitchen range hood suppression system was not inspected every six months as required. The last inspection was conducted on 4/18/2023. An interview with Maitenance Director verified this deficient finding at the time of discovery.	K 324	K324 SS=E Cooking Facilities Corrective Action: Called Summit Fire to come in and conduct the 6-month inspection on 12/12/2023. There was a change in ownership with the company and miscommunication with scheduling the inspection. We have put reminders on the Maintenance Directors, Maintenance Assistant and Administrators calendars to ensure the 6-month inspection occurs timely. The Administrator will audit that this is completed timely. Audits will be reported to QAPI. Actural/proposed completion date: 12/12/2023 Person Responsible for Correction/Monitoring: Maintenance Director, Maintenance Assistant and Administrator.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers	K 355		12/15/23

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K 355	Continued From page 4 Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to install a wall mounted portable fire extinguisher per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and NFPA 10. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/12/2023 at 10AM, it was revealed by observation that a portable fire extinguisher was not mount on the wall but sitting on the floor of the maitenance storage room. An interview with Maitenance Director verified this or these deficient finding(s) at the time of discovery.	K 355	K355 SS=D Portable Fire Extinguishers Corrective Action: The fire extinguisher was replaced with new brackets on 12/15/2023. The annual fire extinguisher inspection is held once a year in September. A calendar invite has been set up for the maintenance director, maintenance assistant and administrator to ensure that the inspections are being completed in a timely manner and installed correctly. Audits will be completed by the administrator to ensure all fire extinguishers are inspcected and installed correctly. Audits will be reported to QAPI. Actual/proposed completion date: 12/15/2023 Person Responsible for correction/monitoring: Maintenance Director, Maintenance Assistant and Administrator.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2023

Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

Re: State Nursing Home Licensing Orders
Event ID: EHHV11

Dear Administrator:

The above facility was surveyed on December 11, 2023, through December 13, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

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
Phone: 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
	00041	A. BUILDING: _____ B. WING _____	C 12/13/2023

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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 12/11/23-12/13/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H54907717C (MN00098336), H54907718C (MN00098942), and H54907719C (MN00086218) and NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is	2 000		

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2 000	Continued From page 2 enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a jacket was offered and/or provided for a resident who rode a bus to an appointment for 1 of 1 resident (R74) reviewed for activities of daily living (ADL) . Findings include: R74's quarterly Minimum Data Set (MDS) assessment dated 8/31/23, indicated intact cognition, no rejection of cares, required one person physical assistance for bed mobility, transfers, ambulation in the room, dressing,	2 920	Corrected	1/12/24

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2 920	Continued From page 3 toileting, and hygiene, utilized a walker and wheelchair, diagnoses included fracture of the lower end of right radius (long bone of the forearm), muscle wasting, pain in right wrist, muscle weakness, and need for assistance with personal care. R74's care plan dated 9/29/23, indicated ADL: altered self-care performance, limited physical mobility R/T (related/to) fracture, pain, weakness, and interventions included dressing: resident requires 1 person limited physical assist with dressing skills. On 12/11/23 at 2:17 p.m., R74 stated today (12/11/23), after lunch she was returning to her room via her wheelchair, and was stopped by a staff member. R74 stated she was told she had a doctor appointment, and staff pushed her in her wheelchair and placed her outside on the bus that provided transportation. R74 stated staff put her on the bus, "just like this with no coat, jacket, and got on the bus". R74 was dressed with long pants, a long sleeve shirt, sweater, socks and shoes. R74 stated she was not warm on the bus ride, and further stated she rode the bus to and from her doctor's appointment with no coat, and stated the bus ride was about five to ten minutes each way. R74 stated staff did not offer her a coat, and stated she would have worn a coat if offered. On 12/12/23 at 9:03 a.m., nursing assistant (NA)-A confirmed yesterday she assisted R74 from lunch via her wheelchair to the bus outside, and stated R74 had a doctor's appointment. NA-A confirmed R74 was not offered or provided a jacket when she went outside, and confirmed she should have offered R74 a coat with the colder weather.	2 920		

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2 920	Continued From page 4 On 12/12/23 at 9:23 a.m., registered nurse (RN)-A, who was the case manager for R74, stated she would expect staff to have asked R74 if she wanted a coat when going outside and riding the bus to the doctor's appointment. On 12/12/23 at 9:27 a.m., during a follow up interview R74 confirmed she wanted a coat when she went outside and rode the bus yesterday. On 12/12/23 at 3:30 p.m., the director of nursing stated she would have expected staff to offer R74 a coat prior to assisting R74 outside for the bus ride to the doctor's appointment. On 12/11/23, Accuweather indicated the weather was high of 41 degrees Fahrenheit, and low of 18 degrees Fahrenheit. The facility Activities of Daily Living (ADLs), Supporting policy dated 11/21/23, indicated: Policy Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care);	2 920		

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2 920	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents's requiring staff assistance, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of resident cares to ensure their personal ADL needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have a water management program consistent with nationally accepted standards, e.g., ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) or CDC (Centers for Disease Control and Prevention). This had the potential to effect all 83 residents who resided in the facility. Findings included: During an interview on 12/13/23 at 9:53 a.m., maintenance worker (MW)-A stated he was responsible for the facility water management program. MW-A explained the actions he took	21375	Corrected	1/12/24

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21375	Continued From page 6 related to the water management program which included testing water for chlorine levels, measuring water temperatures at various sites in the facility, and running water in vacant resident rooms. MW-A was not aware of additional requirements of an effective water management program including completion of a Legionella risk assessment, creating a detailed diagram of the facility water system and following a nationally accepted water management program. During an interview on 12/13/23 at 10:05 a.m., findings were explained to the director of nursing (DON) and registered nurse (RN)-B, who was also the infection preventionist. The DON stated they had a document from ASHRAE titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, but had not yet implemented the standards outlined in that document. RN-B confirmed there had been no cases of Legionnaires disease in the facility. Facility Legionella Water Management Program policy, reviewed on 7/13/20, indicated as part of the infection prevention and control program, the facility had a water management program. The purpose of the program was to identify areas in the water system where Legionella bacteria could grow and spread, and to reduce the risk of Legionnaire's disease. The water management program would be based upon CDC and ASHRAE recommendations for developing a Legionella water management program. The program would have a detailed description and diagram of the water system into the facility, including receiving, cold water distribution, heating, hot water distribution, and waste. Specific measures would be used to control the introduction and/or spread of Legionella (e.g.,	21375		

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21375	Continued From page 7 temperature, disinfectants) and a system to monitor control limits and the effectiveness of control measures. Although the facility water management program policy identified the appropriate measures for an effective water management program, not all of the measures had been implemented, such as a risk assessment to determine vulnerabilities for Legionella, creation of a detailed description and diagram of the water system into the facility, and specific measures to monitor control limits. SUGGESTED METHOD OF CORRECTION: The administrator, or designee could review nationally accepted standards, e.g., ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) or CDC (Center for Disease Control and Prevention) for a water management program that prevents the growth and spread of Legionella, and develop a water management program based on standards. The administrator or designee could monitor implementation water management program for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		