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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FMUZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00640

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245341**
2.STATE VENDOR OR MEDICAID NO.
(L2) **857698100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING**
(L4) **425 N ELM STREET**
(L5) **SAUK CENTRE, MN** (L6) **56378**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2012**

6. DATE OF SURVEY **11/23/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 12/14/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/14/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 14, 2021

CMS Certification Number (CCN): 245341

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

Dear Administrator:

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

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

Effective November 19, 2021 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 14, 2021

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: August 19, 2021

Dear Administrator:

On October 28, 2021, we notified you a remedy was imposed. On November 23, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 19, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 14, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 19, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 19, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FMUZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00640

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(L3) **CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING**
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1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2012**

6. DATE OF SURVEY **11/2/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

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

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Swenson, State Fire Marshall 12/1/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/30/2021 (L20)

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

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____ 2. Facility is not Eligible (L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

November 30, 2021

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: August 18, 2021

Dear Administrator:

On September 14, 2021, we informed you that we may impose enforcement remedies.

On November 2, 2021, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 19, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 19, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 19, 2021.

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

payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by NO DATA, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Centracare Health System-Sauk Centre Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from NO DATA. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding 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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 19, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FMUZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00640

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245341**
2.STATE VENDOR OR MEDICAID NO.
(L2) **857698100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING**
(L4) **425 N ELM STREET**
(L5) **SAUK CENTRE, MN** (L6) **56378**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2012**

6. DATE OF SURVEY **08/19/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
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FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 10/11/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/22/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
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(L27)

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A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
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26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 14, 2021

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: August 19, 2021

Dear Administrator:

On August 19, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 November 19, 2021 (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 February 19, 2022 (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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING _____ B. WING _____	C 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	**425 N ELM STREET SAUK CENTRE, MN 56378**

(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 8/16/21 to 8/19/21, a survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was completed during a recertification survey. CentraCare Health - Sauk Centre was found in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/16/21 to 8/19/21, a standard recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed at the time of the recertification survey. CentraCare Health - Sauk Centre was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated; however, no deficiencies were cited due to actions taken by the facility prior to the recertification survey: H5341029C (MN70514) The following complaint(s) were found to be unsubstantiated: H5341027C (MN75533) H5341028C (MN74881) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/23/2021

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F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to address a repeatedly voiced lack of activities on the weekend for 1 of 2 residents (R2) reviewed for activities. Findings include: R2's annual Minimum Data Set (MDS), dated 8/13/21, identified R2 had intact cognition and required extensive assistance for most activities of daily living (ADLs). Further, the MDS outlined R2 considered having magazines, books or	F 679	Corrective Action: Activity director met with R2 on 8/20/2021 to discuss and review weekend activities. Note left for staff regarding getting activities set up on Sundays for residents. Identification of Others: All residents have the potential to be affected. A survey will be taken with residents by October 8 to inquire if their weekend activity needs are being met. Measure Put Into Place: Residents will be asked upon admission,	10/13/21

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F 679	Continued From page 2 newspapers to read as, "Not Very Important;" however, listening to music, doing things with groups of people, and doing her favorite activities was recorded as being, "Very Important." R2's most recent Activity Admission Assessment V2, dated 8/27/19, identified a section labeled, "Activity Interests," which outlined several questions answered with radio-button style responses to indicate R2's activity interests. R2 was recorded as enjoying several card games, board games, Bingo, word games, people watching, television, radio listening, parties, music events, 'happy hour', and visiting with friends. The assessment outlined R2 desired small group and independent activities in the evening hours, and listed places R2 preferred to do activities including her own room, activity room, lobby, outside and on community outings. R2's care plan, dated 5/3/21, identified R2's activity preferences included listening to music, being around animals, keeping up on the news, doing things with groups of people, and doing her favorite activities (cards, bingo, baking/cooking, painting, large print word searches). The care plan listed a goal which read, "Resident to make choices about her daily activity involvement through the review date," along with several interventions to help R2 meet this goal including offering pet visits, assisting to go outside as COVID-restrictions allowed, and reminding R2 about activities of interest. The care plan last had activities-based interventions added on 5/19/20. On 8/16/21, at 1:20 p.m. R2 was interviewed. R2 explained she enjoyed bingo and dice games, and she routinely attended the activities programs at the nursing home. However, R2 expressed	F 679	quarterly, at resident council, and as needed regarding their interests and weekend activities. Interventions will be put into place to meet their interests. Education will be provided to staff at the all staff meeting on October 20th Monitoring: The activity director/designee will follow-up with residents at least quarterly at care conference, as needed, and at resident council to see if their weekend activity needs are being met. These finding will be reported to the quarterly QA meeting beginning October 13, 2021.	

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F 679	Continued From page 3	F 679		

there needed to be more activities for residents, including herself, to do on the weekends as the weekends were, "pretty dead" and, as a result, caused her to spend a majority of her time on weekends just watching television. R2 stated she had voiced concerns about the lack of organized activities on the weekends to the staff but added there was, "not much they can do" as she thought they, "don't have enough help."

When interviewed on 8/17/21, at 5:57 p.m. nursing assistant (NA)-C stated R2 attended most of the activities offered in the facility; however, NA-C acknowledged R2 had voiced there was a lack of activities on the weekends, especially Sunday. NA-C stated she had last heard R2 voice such concern just the weekend prior and, as a result, the staff attempted to provide her with puzzles or listen to music. However, NA-C voiced, at times, R2 would just have to sit in her room and watch television as there was no structured activities on some weekends. Further, NA-C stated the activities department staff were aware R2 had voiced comments and concerns about a lack of weekend activities.

On 8/17/21, at 6:47 p.m. R2 was observed seated in her motorized scooter seated at a dining room table in the main dining room. Rosary was in progress and R2 was actively participating in the activity with several other residents present.

On 8/18/21, at 8:32 a.m. NA-D and NA-E were interviewed. They described R2 as someone who, "goes to a lot of activities" and typically was able to attend them herself without staff needing to provide assistance to or from them. NA-E voiced R2 had made comments about a lack of

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F 679	Continued From page 4	F 679		

organized activities on the weekends before, and NA-E expressed it was due to a lack of activities staff on the weekends as they were only present from 8:00 a.m. to 2:00 p.m. on Saturdays and 12:00 p.m. to 4:00 p.m. on Sundays. NA-E explained the nursing staff often wanted to help R2 find some activities to do, however, there was rarely time given their other duties and the, "skeleton crew" on the weekends. NA-E voiced it was hard, at times, to even provide R2 with board games or other self-involved activities as the nursing staff, "don't have the keys to the activity room." Further, NA-D and NA-E both expressed the activities department was aware of R2's concern with a lack of activities on the weekend but they were unaware what, if any, actions were being done to help develop more activities or address R2's repeatedly voiced concerns.

R2's medical record was reviewed and lacked evidence R2 had been comprehensively reassessed to help determine what activities could be altered, changed, or added to R2's regimen, both for group-based or individual-based activity programming, despite these ongoing and repeatedly voiced complaints of a lack of activities on weekends to the direct care staff members.

On 8/18/21, at 11:43 a.m. activities assistant (AA)-A was interviewed. AA-A explained the activities department only have "one staff member on the weekends" who often helps pass meals trays in addition to their activities-based duties. AA-A stated a group of residents is then assisted to the laundry folding and, at times, get a "conversing group" organized with coffee and cookies. Afterwards, AA-A stated she tries to catch up on doing visits with other residents but

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F 679	Continued From page 5	F 679		

added, "If I have time." AA-A stated the resident population, including R2, really "don't get a whole lot of activity in on the weekends" due to the "minimal staff." AA-A stated the weekdays often have three staff members present to help organize and lead activities and added she was unaware why there was only one person on the weekends adding, "I guess that's a good question." AA-A expressed she had heard R2 voice concerns about the lack of activities on the weekends and stated she responded to them by asking R2 what she had done on weekends "when you were at home." R2 responded with saying they used to have company over to the house, and AA-A voiced the COVID-restrictions in place were hard to accommodate that desire but acknowledged the facility had recently started allowing volunteers back inside which could help with this. AA-A stated they did have various games or more individual-based activities present in a cabinet on the floor which the nursing staff could offer residents, including R2, when they were bored; however, AA-A voiced the cabinet likely could be reviewed to ensure it had up-to-date items inside and added possibly the floor staff needed to be re-educated on the cabinet and how to address these complaints of residents. Further, with R2's complaints of a lack of activities and their staffing situation on the weekends, AA-A expressed, "Maybe we need to look at things a little differently."

An August 2021 activities calendar was provided which outlined the scheduled activities for the nursing home for the month listed by each day. On the weekend of 8/7/21 to 8/8/21, a total of six activities were offered between the two days including laundry-games, Bingo, and 1:1 visits. On the weekend of 8/14/21 to 8/15/21, a total of

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F 679	Continued From page 6	F 679		

five activities were offered including laundry, horse day, Bingo, and 1:1 visits. On the weekend of 8/21/21 to 8/22/21, a total of four activities were offered including laundry-games, Bingo, and 1:1 visits. Further, on the weekend of 8/28/21 to 8/29/21, again only four activities were offered which included laundry-games, Bingo, Catholic mass (televised), and 1:1 visits.

R2's corresponding Follow Up Question Report(s), dated August 2021, identified R2's activities involvement for the month period. On the weekend of 8/7/21 to 8/8/21, R2 was recorded as watching television, visiting with other residents, attending Rosary, attending Mass, and playing Bingo. Further, on the weekend of 8/14/21 to 8/15/21, R2 was recorded as attending Bingo, attending an animal event, attending Mass, watching television, and reading a magazine or book.

When interviewed on 8/19/21, at 9:09 a.m. the activities director (AD) stated the pandemic restrictions had "hit activities hard" as it didn't allow them to have large group activities. AD described R2 as someone who was "very social" and outlined R2's activity attendance as eight to 16 activities per week. AD stated she felt the activities department was "doing the best we can" with their staffing limitations; however, acknowledged R2 had voiced comments about a lack of activities on the weekends. As a result, they did discuss things R2 could do on her own in her room. AD expressed, in her opinion, that R2's complaints of a lack of activities were her grieving and just wanting the activities to "be back to what it used to be" prior to the pandemic. AD verified R2 had not been comprehensively reassessed for her activities preferences, including what options

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F 679	Continued From page 7 could be attempted, tried or addressed on the weekend hours, since her last assessment in 2019, nor had there been any grievances or anything completed for R2's concerns. Further, AD stated they could re-visit the situation with R2 and possibly "add her to one-to-ones" again to help resolve her concerns but expressed activities on the weekend were "not just the activities people" responsibility as the nursing staff were capable of providing things for the residents to do in their absence, too. A provided Activity Admission Assessment V2 policy, dated 8/2020, identified an activity interest survey is conducted and maintained for each resident to promote their physical, mental and psychosocial well-being. The policy directed each resident would be assessed upon admission to help develop an activity-based care plan to help allow the resident to attend activities of their choosing and interest. This would be "maintained by the activity department and are reviewed as necessary, but at least annually and with significant change."	F 679		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		10/13/21

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F 688	Continued From page 8 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide restorative nursing programs as care planned to maintain abilities for 5 of 5 residents (R28, R40, R18, R20 and R4) reviewed who were to receive a restorative nursing program. Findings include: R28's quarterly Minimum Data Set (MDS) dated 7/9/21, included cognitively intact with a diagnoses of Parkinson's disease. R28 required extensive assistance with transfers, did not ambulate at all in the corridor, but ambulated in room once or twice with one person physical assistance during the look back period. R28 did not receive any therapy, nor did she receive any restorative nursing program. R28's functional maintenance program care plan dated 3/5/21, and revised 6/30/21, included, "Restorative nursing, ambulate distance as tolerated with 4 WW [wheeled walker] with gait belt and one ext [extensive] assist 5x/week [five times per week]. W/C [wheelchair] to follow." "Restorative nursing: Functional maintenance program for Nustep [elliptical work out machine] use Nustep resistance 2 for 5-8 minutes or as tolerates at seat 9 and arms at 10."	F 688	Corrective Action: All staff were educated on the importance of providing restorative nursing and documenting on the restorative nursing that they provided. Staff were also educated to report refusals to the team leader/charge nurse so that further investigation could be done with that resident as to why they are refusing and discuss the risks vs benefits of refusing restorative nursing. Restorative nursing tasks were put into PointClickCare on R28, R40, R18, R20, and R4. Identification of Others: All residents have the potential to be affected. Measure Put Into Place: Restorative nursing tasks were put into PointClickCare on all residents who are to receive restorative nursing so that all staff are able to chart on the restorative nursing that is being provided by them, not just by the Rehab aide. Monitoring: The DON/ADON/Designee will monitor to ensure that restorative nursing programs are being performed as care planned to	

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F 688	Continued From page 9 When interviewed on 8/17/21, at 3:13 p.m. R28 stated she is supposed be offered the Nustep 3 time per week and ambulation 5 times per week, but has only been offered about once a week. R28 stated, she enjoys doing these exercises as it keeps, "her legs moving," and is good for her. R28 stated the reason she is not getting her exercises in is, "They don't have enough help." R28's Walk in corridor documentation for 7/17/21 through 8/18/21, identified R28 had only ambulated on 7/20/21 and 8/11/21. She had refused to ambulate 4 times during the past 30 days. The documentation did not show if ambulation was offered five times a week as directed in care plan. R28's Restorative nursing documentation for the Nustep use indicated R28 used the Nustep on 7/20/21, 8/11/21, and 8/17/21 and refused 3 days. There was no indication why R28 had not received the program three times per week as directed. When interviewed on 8/18/21, at 1:26 p.m. nursing assistant (NA)-B stated R28 should receive assistance with the Nustep every Tuesday, Wednesday and Friday and ambulate in hall five times a week. However, the restorative nursing aide gets pulled from duties to assist with nursing assistant duties when they are short staffed, or someone calls in sick. When this happens, which is several times a week, the restorative programs do not get done. If this happens, she does not document the program in any way. R28 does not normally refuse to participate in the program. When interviewed on 8/19/21, at 9:12 a.m. registered nurse (RN)-B stated, the restorative	F 688	those who are to received restorative nursing. Will monitor weekly for 1 month; then twice a month for 1 month; then as needed. If not done, will provide education with the staff involved. The findings will be reported to the QAA meeting beginning October 13, 2021.	

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	245341	A. BUILDING _____ B. WING _____	C 08/19/2021

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F 688	Continued From page 10	F 688		

aide often gets pulled when they need staff to work on the floor. R28 should be getting on the bike 3 times per week and confirmed by looking in the computer that this was not being done. RN-B stated that it is important for all residents to be getting restorative care as they do not want a decline in the residents functional ability.

When interviewed on 8/19/21, at 9:18 a.m. the director of nursing (DON) stated, R28 should be getting restorative care three times a week but only has received it twice in month of august and should have received it at least 6-8 times by now. DON further stated it was important for all residents to get their restorative nursing programs to maintain their current abilities and to prevent decline, if they can.

R40's quarterly MDS dated 6/25/21, included severe cognitive impairment with a diagnosis of dementia. R40 required extensive staff assistance with most activities of daily living (ADL's). Therapy had ended 4/12/21, and did not receive a restorative nursing program.

When interviewed on 8/16/21, at 1:57 p.m. family member (FM)-A stated, R40 was not receiving the exercise program that therapy ordered for him. FM-A stated, R40 has been weaker lately, but felt it was medication related.

R40's care plan revised 7/27/21, indicated R40 required extensive one to two assist with bathing, bed mobility, dressing and walking. R40's care plan further indicated weights two times per week on Tuesday and Friday and walk with staff in room/hallway one to two times per day with front wheeled walker and wheelchair to follow.

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F 688	Continued From page 11	F 688		

R40's restorative documentation dated 7/17/21 through 8/17/21, directed staff to compete exercises once a day 3-5 days per week. R40's exercise was documented as being completed on 8/2/21 and 8/12/21 only. The documentation indicated R40 was either not available or refused on 2 days also. There was no indication R40 had been offered the exercise program any other days.

When interviewed on 8/18/21, at 1:26 p.m. NA-B stated, R40 is supposed to be working with the theraband, lower legs, and walking and reports this was not getting done because the restorative aide was always getting pulled to work on the floor and there was no time to complete the exercise program for R40.

When interviewed on 8/18/21, at 9:11 a.m. LPN-A stated therapy no longer works with R40 but he is on a walking program 1-2 times a day if he allows. However, this was not getting done because of staffing issues.

When interviewed on 08/18/21, at 9:17 a.m. LPN-A stated that the restorative aide gets pulled when there is a call in or they are short staffed. LPN-A stated they try to get all of the cares done but can't really say what isn't getting completed. However, the restorative nursing programs are often the first to go when they don't have enough staff.

When interviewed on 08/18/21, 12:49 p.m. RN-A stated that R40 participates with the rehab program but not sure if this is getting completed all the time. RN-A stated that the restorative aide does get pulled when staffing is short and they try to get the rehab program completed.

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F 688	Continued From page 12	F 688		

R18's annual MDS dated 6/25/21, included, cognitively intact, did not reject cares, required extensive assistance for most ADL's and did not ambulate. R18 did no receive a restorative nursing program.

R18's care plan dated 5/19/21, included to walk in room/corridor with extensive assist of one short distances with a walker. In addition, the care plan identified a functional maintenance program, staff were directed to: "Restorative nursing: Complete 15 reps [repetitions] of the following exercises to BUE [bilateral upper extremities] with yellow theraband. Complete 3-5 days a week. Please walk patient as far as she tolerates with FWW [front wheeled walker] and CGA [contact guard assist]/Min [minimum] A [assist] of 1 and wc follow once a day to increase strength and endurance."

R1's Functional Maintenance Program from physical therapy dated 1/4/21, directed: "Please walk patient as far as she tolerates with FWW and CGA/Min A of 1 and WC follow once a day to increase strength and endurance."

When interviewed on 8/19/21, at 11:07 a.m. R18 stated, she does her exercises and walks, but is only offered maybe once a week. The exercises have helped her keep her arms moving and she enjoys it. She did not know why she was not being offered the program more often.

Documentation of R18's restorative nursing program with exercises and ambulation was requested from the facility, but not provided.

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F 688	Continued From page 13	F 688		

R20's quarterly MDS dated 6/25/21, indicated severe cognitive impairment with a diagnosis of Alzheimer's disease. R20 required supervision with transfers and ambulation in the corridor. R20 did not receive a restorative nursing program.

R20's care plan dated 9/18/20, indicated R20 needs extensive one assist with bed mobility, dressing, and walking. R20's care plan further indicated restorative nursing related to weakness with interventions of seated exercises, ankle pumps, hip exercises and glut sets (buttocks muscles) 10-20 reps, walking program in hallway along with upper extremity functional maintenance program.

R20's Functional maintenance program by occupational therapy, dated 10/12/20, indicated rehab aide to complete bilateral upper extremities with yellow theraband 3 days a week.

Functional maintenance program by physical therapy dated 12/30/20, indicated R20 to do seated exercises ankle pumps, hip exercises and glut sets (butt muscles) 10-20 reps, walking program in hallway 1 time a day and 3-5 times per week due to weakness after COVID.

During interview on 8/19/21, at 11:10 a.m. R 20 stated she likes doing the exercises when the staff come and help her but they do not come all the time. R20 stated it helps her keep moving.

Documentation of R20's restorative nursing (functional maintenance program was requested, but not provided by the facility.

R4's annual minimum data set dated (MDS)

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F 688	Continued From page 14	F 688		

dated 5/21/21, indicated moderate cognitive impairment with diagnoses including dementia and heart failure. R4 was able to ambulate with supervision, and required extensive staff assistance with most other ADL's. R4 did not receive a restorative nursing program.

R4's care plan printed 5/19/21, identified R4 restorative nursing related to weakness with interventions of upper extremity functional maintenance program three times per week. Staff were to encourage walking in hallway with FWW independently.

When interviewed on 8/19/21, at 11:47 a.m. R4 stated the restorative aide comes in most the time but unsure how many times a week she actually comes. R4 stated that the aide misses some times but doesn't feel like she is declining.

Documentation of R4's restorative nursing program was requested, but not provided by the facility.

When interviewed on 8/19/21, at 10:28 a.m. assistant director of nursing (ADON) stated, it was important for residents to be getting their restorative care and the residents should be having this done to prevent decline and to maintain strength. ADON further stated that the restorative aide typically gets pulled when there is a call in or when she was on vacation they tried to fill the shifts.

When interviewed on 8/19/21, at 10:34 a.m. NA-B stated with P4, P18, and P20 they are all on restorative program as well, and stated when the restorative aide is pulled, the program for all the residents are not getting completed. NA-B further

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F 688	Continued From page 15 stated they try to walk the residents when time allows, but it is not always being completed due to staffing. NA-B further stated that it was important for residents to participate in the restorative program to prevent freeze up of joints and decrease in strength of the resident. Restorative hours printed 8/19/21 for the past 30 days was provided and identified 5 times (excluding weekends) the restorative aide was pulled to work the floor, or not filled. In addition the rehab aide was on vacation and not replaced 8/9/21 through 8/12/21. A facility Restorative Nursing Program-long term Care policy dated 2/21, included, "A restorative nursing program defines nursing interventions that promote the resident's ability to live as independently and safely as possible. The restorative nursing program will be carried out by a nursing assistant that has been trained in the techniques to promote resident involvement. The restorative nursing program is overseen by a licensed nurse."	F 688		
F 868 SS=C	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role;	F 868		10/13/21

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F 868	Continued From page 16 §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assurance (QA) committee held meetings with the required members on a, at minimum, quarterly basis. This had potential to affect all 43 residents residing in the facility at the time of the survey. Findings include: A provided Quality Assurance and Performance Improvement Plan, dated 11/2020 to 11/2021, outlined the purpose of the committee was to take proactive approaches to enhance the care and engagement of the way residents, caregivers and other partners were served. The plan outlined, "The Care Center Quality Assessment and Assurance Committee meets quarterly to review data and to analyze and discuss opportunities for improvement through monitoring of data." During the recertification survey, from 8/16/21 to 8/19/21, documentation was requested demonstrating the QA meeting(s) held for the past calendar year. A series of three untitled document was provided which had the date and attendance of the previous years' QA meetings. These identified a meeting was held on 7/14/20, 4/28/21, and 7/14/21. There was no evidence provided	F 868	Corrective Action: QAA meeting will be held quarterly in person or via web-ex. If scheduling conflicts, the meeting will be rescheduled, not canceled. Identification of Others: All residents have the potential to be affected. Measure Put Into Place: QAA meeting will be held quarterly in person or via web-ex. If scheduling conflicts, the meeting will be rescheduled, not canceled. Monitoring: The DON, Medical Director or his/her designee, and at least 3 other members of the facility's staff (at least one of who must be the administrator, owner, a board, member or other individual in a leadership role) will be in attendance quarterly. Next QAA meeting is scheduled for October 13, 2021.	

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F 868	Continued From page 17 demonstrating a meeting had been held, either in-person or via virtual network or telephone, between 7/14/20 and 4/28/21 (over eight months in between). On 8/19/21, at 11:16 a.m. the director of nursing (DON) was interviewed and explained the QA committee was currently working on several projects including a pain-related performance improvement plan (PIP), infection control measures with the pandemic, and new building construction details. The DON verified there had not been a QA meeting held, either in-person or remotely (i.e., via Webex, Teams), from 7/14/20 to 4/28/21 and explained she had sent meeting invitations and several people could not attend, so the meetings were just canceled and not held. Further, despite the meetings being canceled, the DON voiced she had not sent any QA-related data or documents to the committee members for review or input during that timeframe.	F 868		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an oxygen machine was kept in a safe and sanitary condition to ensure proper function for 1 of 2 residents (R21) observed to use oxygen on the survey. Findings include: R21's annual Minimum Data Set (MDS), dated	F 908	Corrective Action: R21s Oxygen concentrator filter was cleaned on 8/18/2021. Licensed staff were educated on the Oxygen Administration-Long Term Care policy that states "filters for the oxygen concentrators (if applicable) will receive cleaning as recommended by the manufacturer".	10/1/21

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F 908	Continued From page 18 6/25/21, identified R21 had intact cognition. Further, the MDS outlined R21 demonstrated shortness of breath with exertion and while at rest, and used oxygen therapy while a resident at the nursing home. On 8/16/21, at 10:24 a.m. R21 was observed laying in bed in his room. R21 had a visible nasal cannula in place which was connected to a NewLife Elite AirSep oxygen concentrator positioned along the wall. This machine was inspected which identified a single, approximately six inch filter on the back of the machine which was covered with copious amounts of dark gray, clumping dust and debris. R21 denied being short of breath at this time; however, he was "not really sure" who cleaned the machine's filter or monitored it to ensure proper function. During subsequent observation, on 8/18/21 at 11:59 a.m. R21's oxygen concentrator continued to have the same visible, copious dust and debris present on the single filter. R21 was not using the oxygen at this time. On 8/18/21, at 12:13 p.m. licensed practical nurse (LPN)-A was interviewed and verified she was assigned to care for R21 and often worked with him several days a week. LPN-A stated R21 had COPD (chronic obstructive pulmonary disease) and emphysema which required him to use his oxygen from the concentrator primarily during the night hours when he was sleeping to avoid becoming short of breath. LPN-A explained the nurses were responsible to ensure resident's oxygen equipment, including the filters on the concentrators, were kept clean and it was tracked through the resident Treatment Administration Record (TAR). However, LPN-A reviewed R21's	F 908	Identification of Others: Reviewed the eMar of other residents using oxygen. Measure Put Into Place: An order was placed in the STAR (eMar) of all residents using oxygen that reads "Clean O2 concentrator filter weekly on Sunday morning". This order is part of the oxygen order set that is implemented when anyone is started on oxygen. Monitoring: The DON/ADON/Designee will monitor to ensure that oxygen machines are kept in a safe and sanitary condition. Will monitor 1 day per week for 1 month; then 2 times per month for 1 month; then as needed. If not clean, will provide education with the staff involved. These finding will be reported to the Quarterly QAA meeting beginning October 13, 2021.	

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F 908	Continued From page 19	F 908		

TAR and voiced there had been no intervention or direction set-up on the record to ensure this was done for some reason. LPN-A then observed R21's oxygen concentrator in his room and voiced the filter was heavily soiled and needed to be cleaned. LPN-A stated she would ensure the intervention for routine cleaning was added to the TAR and added it was important to ensure the machine's filter was cleaned and free of debris otherwise the machine "[isn't] going to filter the air properly" and R21 would not get "the best oxygen" he could. LPN-A expressed she was unaware the last time the machine had been checked or the filter had been cleaned.

An undated NewLife Elite Oxygen Concentrator Service Manual identified a section labeled, "Patient Instructions," which directed the Air Intake Gross Particle Filter should be cleaned on a weekly basis using soap and water. Further, an attached Troubleshooting Chart outlined some potential issues which could occur due to air intake and/or filtration issue(s). These included restricted airflow through the unit which could cause the machine's compressor to shut down intermittently or the compressor not staring due to excessive heat.

When interviewed on 8/18/21, at 1:06 p.m. the assistant director of nursing (ADON) stated R21 used oxygen mostly at night for COPD, and the nurses should be cleaning his oxygen equipment, including the concentrator filter, according to the facility policy. The ADON stated this should be completed and tracked on the resident's TAR. The ADON expressed it was important to ensure oxygen equipment was kept in a clean and safe condition to help prevent respiratory infections and because soiled equipment was "just gross."

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F 908	Continued From page 20 Further, the ADON stated the facility had no formal audit system in place to ensure these items and equipment were being cleaned in accordance with their policy. A provided Oxygen Administration - Long Term Care policy, dated 3/2021, identified a section labeled, "Oxygen Concentrators," which directed, "Filters for the oxygen concentrators (if applicable) will receive cleaning as recommended by the manufacturer."	F 908		

Electronically delivered
October 28, 2021

Administrator
Centracare Health System-Sauk Centre Nursing Home
425 N Elm Street
Sauk Centre, MN 56378

RE: CCN: 245341
Cycle Start Date: August 19, 2021

Dear Administrator:

On September 14, 2021, we informed you that we may impose enforcement remedies.

Compliance with the Life Safety Code (LSC) deficiencies cited on August 18, 2021 has not yet been verified.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 19, 2021. (42 CFR 488.417 (b))

The CMS Region V Office will notify your Medicare Adminstrative Contractor (MAC) that the denial of payment for new admissions is effective November 19, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 19, 2021. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Centracare Health System-Sauk Centre Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 19, 2021. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	**425 N ELM STREET** **SAUK CENTRE, MN 56378**

(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	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Centracare Health Systems Sauk Centre Nursing Home 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		09/22/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

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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. Centracare Health System Sauk Centre Nursing Home is a two-story building with no basement and is fully sprinkler protected. The original building was constructed in 1973 and was determined to be of Type II(222) construction. In 1994, an addition was added to the east that was determined to be of Type II(111) construction. In 2008 the facility moved the 2 hr separation in the West wing, adding six resident rooms to the Nursing Home. The addition was part of the original hospital constructed in 1949 and was	K 000		

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

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K 000	Continued From page 2 determined to be of Type II (222) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, installed in accordance with NFPA 72 "The National Fire Alarm Code" (2010 edition). The fire alarm system is monitored for automatic fire department notification. All hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code 2015 edition. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility has a capacity of 60 beds and had a census of 43 at the time of the survey.	K 000		
K 321 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches	K 321		10/31/21

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K 321	Continued From page 3 from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a soiled utility door per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/18/2021, between 9:30 AM to 1:30 PM, it was revealed that Soiled Utility Room W2 did not properly latch when tested. This deficient condition was verified by the Facilities Maintenance Director.	K 321	Door and hardware will be adjusted by maintenance for proper latching. Hardware will be replaced if defective. A TMS Maintenance PM work order will be added quarterly to ensure testing of doors.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		10/31/21

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

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K 345	Continued From page 4 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 record review and staff interview, the facility failed to maintain the fire alarm system as required by NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code 2010 edition, section 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/18/2021, between 9:30 AM to 1:30 PM, it was revealed the devices tested in 2021 were more than the amount tested in 2020. The documentation provided did not account for the added devices. This deficient condition was verified by the Facilities Maintenance Director.	K 345	Simplex Fire Protection will provide the inspection and documentation for the device testing. The documentation for additional devices will be added to the Fire Marshal manual by Maintenance.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an	K 351		10/31/21

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 351	Continued From page 5 approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1, and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, section 8.15.7.3. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/18/2021 between 09:30 AM to 1:30 PM, it was revealed a sprinkler head was not installed above a wood studded enclosure in the nursing home storage area. This deficient condition was verified by the Facilities Maintenance Director.	K 351	Summit Fire Protection will add the necessary sprinkler heads to the enclosure.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101	K 363		10/31/21

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 6 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 363		

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

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K 363	Continued From page 7 Based on observation and staff interview, the facility failed to maintain two resident room doors with impediments to the closing of the door in accordance with the 2012 Life Safety Code (NFPA 101) section 7.1.10.1 and 7.2.1.5. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1) On 08/18/2021, between 9:30 AM to 1:30 PM, it was revealed that resident room door 139 would not shut and positively latch when tested. 2) On 08/18/2021, between 9:30 AM to 1:30 PM, it was revealed that resident room door 123 was held open with a non-approved object. These deficient conditions were verified by the Facilities Maintenance Director.	K 363	Doors and hardware will be adjusted by Maintenance for proper latching. Hardware will be replaced if defective. A TMS Maintenance PM work order will be added quarterly to ensure testing of door.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain	K 521	Smoke and fire dampers will be tested every 4 years following the manufacturers	8/19/21

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

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K 521	Continued From page 8 the facility's heating, ventilation, and air conditioning in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1, and NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 Edition, Sections 19.4.9, 19.4.10 and 19.5.5 and NFPA 105 Standard for Smoke Door Assemblies and Other Opening Protectives 2010 Edition, Sections 6.5.11, 6.5.12 and 6.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/18/2021, between 9:30 AM to 1:30 PM, it was revealed that the facility had exceeded the required four-year testing of the smoke and fire dampers. Current documentation shows the last inspection completed was 02/23/2017. This deficient condition was verified by the Facilities Maintenance Director.	K 521	recommendations. A TMS Maintenance PM work order will reoccur every 4 years. Testing of fire and smoke dampers was completed by maintenance on August 19, 2021 and documentation was added to Fire Marshal manual.	
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	K 712		8/19/21

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

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K 712	Continued From page 9 by: Based on a review of available documentation and staff interview, the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/18/2021, between 09:30 AM to 1:30 PM, it was revealed the facility did not vary dates and times in the last calendar year. This deficient condition was verified by the Facilities Maintenance Director.	K 712	Varying dates/times will be added to the shared Maintenance calendar. Maintenance will confirm the drills are completed on scheduled date.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff	K 761	Doors and hardware will be adjusted by	10/31/21

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	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

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K 761	Continued From page 10 interview, the facility failed to maintain five fire-rated doors and is required by NFPA 101 (12) Life Safety Code, section 7.2.1.15.2 & 7.2.1.15.4 and NFPA 80, 2010 edition, section 5.2.4.2. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: On 08/18/2021, between 09:30 AM to 1:30 PM, it was revealed that several of the facility fire doors did not latch or had space around the door handles. - 2 Dietary Storage doors would not positively latch -B7 Holes by the hardware of the handle -B3 Holes by the hardware of the handle and does not positively latch -B13 Did not positively latch These deficient conditions were verified by the Facilities Maintenance Director.	K 761	Maintenance for proper latching. Hardware will be replaced if defective. Holes in door will be filled with an approved rated material. A TMS Maintenance PM work order will be added quarterly to ensure testing of door.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	**425 N ELM STREET** **SAUK CENTRE, MN 56378**

(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 901	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and ensure the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99, 2012 Edition, Health Care Facilities Code Chapter 4 and per NFPA 101 (2012 edition), Life Safety Code. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/18/2021, between 9:30 AM to 1:30 PM, it was revealed the required annual risk assessment was not completed per NFPA 99. This deficient condition was verified by the Facilities Maintenance Director.	K 901	BioMed provided the proper documentation to Maintenance. Maintenance will add documentation to the Fire Marshal manual. This documentation will be provided by BioMed yearly.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this	K 914		8/19/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. BUILDING **01 - NURSING HOME - 01** B. WING _____	**08/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	**425 N ELM STREET** **SAUK CENTRE, MN 56378**

(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 914	Continued From page 12 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 on record review and staff interview, the electrical testing and maintenance were not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 and 6.3.4.1.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/18/2021 between 09:30 AM to 1:30 PM, it was revealed the required annual there was no documentation for the annual receptacle inspection in resident rooms since 07/05/2019. This deficient condition was verified by the Facilities Maintenance Director.	K 914	Maintenance staff will complete the annual receptacle testing. The testing will be added to the TMS Maintenance PM work order system to reoccur annually. The receptacle testing was completed by Maintenance August 19, 2021. Documentation was added to the Fire Marshal manual.	