



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 10, 2025

Administrator
Halstad Living Center
133 FOURTH AVENUE EAST
HALSTAD, MN 56548

RE: CCN: 245569

Cycle Start Date: June 04, 2025

Dear Administrator:

On July 10, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Sarah Lane'.

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

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 12, 2025

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

RE: CCN: 245569
Cycle Start Date: June 4, 2025

Dear Administrator:

On June 4, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 September 4, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 4, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

Halstad Living Center

June 12, 2025

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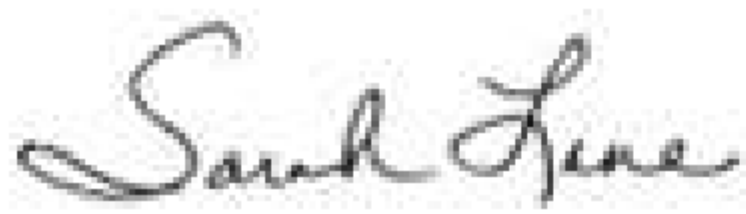
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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

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

Feel free to contact me if you have questions.

Sincerely,



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

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

PRINTED: 06/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245569	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER HALSTAD LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 6/2/25 to 6/4/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 6/2/25 to 6/4/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to-	F 577			6/12/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2025

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

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F 577	Continued From page 1 (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure three years of survey results were readily accessible for residents or visitors. This deficient practice had the potential to affect all 43 residents currently residing in the facility and any visitors. Findings include: During an observation on 6/2/25 at 12:23 p.m., the facility survey results were located in a binder which was placed in a plastic bin attached to the wall across from the dining room approximately			F 577	Survey results from 11/15/22, 12/22/22, 9/21/23, and 4/17/24 were located and inserted into the designated binder. The binder was updated and made accessible to residents and visitors on 6/3/2025. Measures to Prevent Recurrence: A formal policy has been implemented requiring that all new survey results and plans of correction be added to the binder within 48 hours of receipt. A clearly marked and accessible binder location has been designated near the facility entrance.		

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F 577	Continued From page 2 four feet from the ground. The last survey results noted in the folder were from a recertification survey dated 8/23/23. In review of survey results from 11/22 to 6/2/25, the binder lacked the following survey results: -11/15/22, an abbreviated survey was completed. -12/22/22, an abbreviated survey was completed. -9/21/23, an abbreviated survey was completed. -4/17/24, a recertification survey was completed. During an interview on 6/2/25 at 1:40 p.m., administrator confirmed survey results prior to and after 8/23/23, were not included in the binder and were not readily accessible for the residents or visitors to review. Administrator stated her expectation was the folder would have been kept up to date with all surveys. A policy on posting survey results was requested however, one was not provided.	F 577	Signage has been posted in public and common areas notifying residents and visitors of the availability of the survey results binder. Systemic Changes: The Administrator and Director of Nursing were in-serviced on 6/4/2025 regarding federal requirements under 42 CFR §483.10(g)(10)-(11). Staff were educated on how to assist residents and visitors with accessing the binder and reviewing its contents. A review of facility systems and processes related to survey result availability has been incorporated into orientation and ongoing training. Monitoring Procedures: The Administrator will conduct monthly audits of the binder to ensure it remains current and accessible. Results of these audits will be reported to the facility's QAPI Committee during quarterly meetings. Any findings of noncompliance will be addressed immediately and corrective action documente		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.	F 851			6/12/25

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

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F 851	Continued From page 4 §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and editable data, during 1 of 1 quarters reviewed (Quarter 1), October 1-December 31st 2024, to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This deficient practice had the potential to affect all 43 residents residing in the facility. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705 D for quarter 1 identified excessively low weekend staffing, one star staffing rating, no RN hours for every day in quarter 1 and failed to have licensed nursing coverage 24 Hours/Day for every day in quarter 1. Review of staff timecards from the first quarter verified the facility did not have excessively low weekend staffing. Further identified, the facility had RN coverage for at least 8 hrs per day and the facility had licensed nursing coverage 24 Hours/Day. During an interview on 6/3/25 at 10:33 a.m.,	F 851	The Administrator verified corrected PBJ data for Quarter 1 on 6/4/25. Accurate staffing levels, including RN and weekend coverage, were verified using payroll and timecard records and successfully submitted to CMS. Measures to Prevent Recurrence: The Administrator and Director of Nursing were re-educated on the PBJ submission process, data accuracy requirements, and CMS validation tools. A second-level review protocol was established. Before each submission, PBJ data will be cross-checked by a designated back-up reviewer to ensure accuracy and prevent clerical errors. A checklist was implemented to flag potential errors, such as hours over 24 in one day, before final file uploads. Systemic Changes: The Administrator completed CMS PBJ training modules on 6/6/25 to reinforce regulatory understanding. The facility's PBJ policy was revised on 6/7/25 to include: Validation report review within 24 hours of submission Documentation of all quarterly PBJ audit		

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F 851	Continued From page 5 administrator verified she was the one that submitted PBJ reports for the facility and she was unaware the facility was triggering for the areas listed above on the PBJ report. Administrator stated on 12/2/24, the director of nursing (DON) hours were submitted as 26.25 hours and anytime staff hours were submitted for over 24 hours in a day, all the staff hours for that whole quarter were rejected. Administrator further stated it was a clerical error that caused all of the PBJ data to be rejected for the quarter. Administrator stated her expectation was that all PBJ data would have been submitted accurately to reflect the correct amount of staffing for the facility. Review of a facility policy titled Payroll Based Journal revised 10/24, identified it was the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. Further identified the administrator was responsible for reviewing validation reports and ensuring that any needed corrections were made before the quarterly deadline.	F 851	checks Immediate re-submission upon rejection or discrepancy detection The revised policy will be reviewed with the facility's QAPI team. Monitoring Procedures: Monthly audits of PBJ entries will be conducted for the next two quarters by the Administrator and the assigned back-up reviewer. Audit findings will be reviewed at the monthly QAPI meetings. A quarterly report will be submitted to the governing body summarizing PBJ compliance and any errors found.		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/03/2025. At the time of this survey, Halstad Living Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Halstad Living Center was built in 1977 as a 1-story building without a basement and was determined to be Type II (000) construction. In 1990 a 1-story addition to the dining room was constructed to the east of the original building and was determined to be Type II (111) construction. In 1998 a dining addition was constructed to the west of 200 wing and an addition to the south to connect to the apartment building. These additions are 1 story without a basement and were determined to be of a Type II (111)			K 000			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page 2 construction. The building is divided into 5 smoke zones with 1/2 hour fire rated barriers. The entire building is sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code". Hazardous areas have automatic fire detectors that are on the fire alarm system. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building. The facility has a capacity of 44 beds and had a census of 44 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K 000			
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,			K 324			6/12/25

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K 324	Continued From page 3 or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain cooking facilities per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 06/03/2025 at 11:14 AM, it was revealed by a review of available documentation that the suppression system in the main kitchen had not been inspected at the proper intervals. The most recent inspection occurred on November 12, 2024, and prior to that, the last inspection occurred on January 8, 2024. Maintenance on this system should be conducted at least every 6 months. An interview with the Maintenance Director			K 324	Inspections have been added to maintenance care program and will notify Maintenance Director of upcoming inspections a month prior to the inspection. Maintenance director will contact Summit Fire (Russ Holms) and make sure inspections are scheduled. The Maintenance Director will complete the Life Safety Form after inspection and will be in the binder with the inspection forms.		

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

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FORM APPROVED
OMB NO. 0938-0391

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K 324	Continued From page 4			K 324			
K 345 SS=F	verified this deficient finding at the time of discovery. Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.2, and 14.6.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/03/2025 at 11:35 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation of smoke detector sensitivity testing being completed on the smoke detectors in the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 345	Inspections have been added to maintenance care program and will notify Maintenance Director of upcoming inspections a month prior to the inspection. Maintenance director will contact Summit Fire (Russ Holms) and make sure inspections are scheduled. The Maintenance Director will complete the Life Safety Form after inspection and will be in the binder with the inspection forms.		6/12/25

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K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Base on observation and a review of available documentation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, and 4.3. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 06/03/2025 at 11:11 AM, it was revealed by review of available documentation that the annual sprinkler system testing and maintenance had not	K 353	Inspections have been added to maintenance care program and will notify Maintenance Director of upcoming inspections a month prior to the inspection. Maintenance director will contact Summit Fire (Russ Holms) and make sure inspections are scheduled. The Maintenance Director will complete the Life Safety Form after inspection and will be in the binder with the inspection forms.	6/12/25	

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NAME OF PROVIDER OR SUPPLIER HALSTAD LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST HALSTAD, MN 56548		
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K 353	Continued From page 6 occurred since April 18, 2024.	K 353			
K 521 SS=E	An interview with the Maintenance Director verified this deficient finding at the time of discovery. 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 inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/03/2025 at 11:35 AM, it was revealed by a review of available documentation that the facility could not provide a current fire damper inspection report for an inspection that would have occurred in the last 4 years.	K 521	Inspections have been added to maintenance care program and will notify Maintenance Director of upcoming inspections a month prior to the inspection. Maintenance director will contact Summit Fire (Russ Holms) and make sure inspections are scheduled. The Maintenance Director will complete the Life Safety Form after inspection and will be in the binder with the inspection forms.	6/12/25	

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K 521	Continued From page 7 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521			
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/03/2025 at 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the first shift of the 4th quarter of 2024. An interview with the Maintenance Director verified this deficient finding at the time of	K 712		6/12/25	

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K 712	Continued From page 8 discovery.	K 712			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 12, 2025

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

Re: Event ID: FYIT11

Dear Administrator:

The above facility survey was completed on June 4, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00764	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER HALSTAD LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST HALSTAD, MN 56548		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/2/25 to 6/4/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. Minnesota Department of Health is documenting	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

06/19/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00764	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2025
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2 000	Continued From page 1 the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			