Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 17, 2025

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: October 24, 2024

Dear Administrator:

On December 10, 2024, we notified you a remedy was imposed. On January 16, 2025 the Minnesota Departments 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 January 2, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 10, 2024, 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 January 24, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 2, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 17, 2025

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

Re: Reinspection Results
Event ID: ICJ812

Dear Administrator:

On December 11, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 24, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 10, 2024

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: October 24, 2024

Dear Administrator:

On October 29, 2024, we informed you that we may impose enforcement remedies.

On December 9, 2024, 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.

The deficiency not corrected is as follows:

K0321 - Hazardous Areas - Enclosure

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 24, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 24, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 24, 2025.

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.

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

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 $12,924, 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 January 24, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Norris Square will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 24, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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.

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 April 24, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 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:

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING **01 - PRESBYTERIAN HOMES OF COTTAGE GROVE** B. WING _____	R **12/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

(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 Based on an on-site revisit, the facility is not in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 000}		
{K 321} SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 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 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322)	{K 321}		12/31/24

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

Electronically Signed | 12/13/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING **01 - PRESBYTERIAN HOMES OF COTTAGE GROVE** B. WING _____	R **12/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

(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 321}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.2.1, 18.3.6.3.11, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/23/2024 between 09:15 AM and 1:15 PM, it was revealed by observation that the following was found: 1. The main trash chute collection room on 1st floor double doors will not shut and latch. 2. The trash chute door at bottom of shaft doest not have a fusible link in the chain that holds the door open. 3. The storage / sprinkle riser room has an 1 foot and 3 foot opening that has several conduit pipes going through the ceiling that is filled with a orange in color spray foam. No documentation could be provided for proper fire-stopping rating. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	{K 321}	The facility will maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.2.1, 18.3.6.3.11, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. To comply, The fusible link at the bottom of the trash chute will be replaced on or before December 31st, 2024.. With the manufacturer specified 165° F. device. Inspecting the fusible link will be added as a monthly inspection task to the Electronic Work Order System (EWOS) existing monthly fire door inspection task. The Regional Engineering Manager (REM) will be responsible for adding this task on or before December 13th, 2024. The Environmental Services Director (ESD) will be responsible for ensuring this monthly task is completed promptly. The REM will ensure the tasks have been completed during the document review portion of the Annual Facility Review. (AFR) The gaps in the fire barrier wall in the storage/sprinkler room will have the non compliant foam removed and will be properly fire stopped with code approved fire retardant sealant 3M Fire Barrier Sealant 25WB Plus on or before December 31st, 2024. The ESD and the REM will be responsible for ensuring these gaps are properly sealed. The REM will inspect all spaces for fire barrier gap compliance during the AFR.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 29, 2024

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: October 24, 2024

Dear Administrator:

On October 24, 2024, 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 January 24, 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 April 24, 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

Travis Z. Ahrens
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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016

(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 10/23/2024, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/21/24 through 10/24/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H56379702C (MN107644). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		11/20/24

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

Electronically Signed | 11/07/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016

(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
F 584	Continued From page 1 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING _____ B. WING _____	C 10/24/2024

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F 584	Continued From page 2 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clean and maintain a resident's wheelchair for 1 of 1 resident (R4) reviewed for safe, clean, and homelike environment. Findings include: R4's quarterly Minimum Data Set (MDS) dated 9/4/24, indicated R4 was cognitively intact, was dependent on staff for mobility in a manual wheelchair, required partial/moderate assistance with transfers and set up/clean up assistance with meals. The MDS indicated R4 would have a loss of liquids/solids from mouth when eating or drinking. R4's diagnoses included progressive supranuclear ophthalmoplegia (a condition affecting the movement of the eyes), dysphagia (a condition affecting one's speech), and anxiety. R4's care plan dated 9/6/24, indicated R4 had an activities of daily living (ADL) self-care performance deficit and instructed staff to assist as needed with dressing, grooming, eating, bathing, and mobility. The care plan instructed staff to place a clothing protector on shirt and lap during meals. R4's clinical nutrition assessment dated 8/29/24, indicated R4 required an extra clothing protector for lap protection from spills and that R4 had a loss of food/liquids from mouth. R4's nursing assistant care sheet (south unit) dated 10/22/24, indicated R4's bath day was	F 584	1. Immediate Correction Action Taken: All wheelchairs were immediately inspected, and any found to be unclean were thoroughly cleaned and disinfected. All Residents who use wheelchairs had them inspected and those that were visibly unclean were provided with interim, clean wheelchairs while their own were being sanitized. 2. Changes Revised Cleaning Protocol: Updated our facility’s wheelchair maintenance protocol which includes weekly cleaning and inspection of all wheelchairs in addition to as-needed cleaning when visibly soiled. Implemented a checklist to document each wheelchair’s cleaning date, time, and staff member responsible. Staff Training: All nursing staff received training on the revised protocol, emphasizing the importance of a clean environment to resident dignity, comfort, and infection control. Staff instructed to report and address any visibly unclean wheelchairs immediately, even if outside scheduled cleaning. 3. Monitoring Ongoing Compliance: Audits conducted by Nursing and Supervisors twice a week for four weeks and monthly until wheelchair cleanliness compliance is achieved.	

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F 584	Continued From page 3 Monday mornings and laundry was pulled from R4's room on Sunday evenings. The south unit laundry/wheelchair cleaning schedule dated 6/13/24, indicated R4's room number was listed on Sunday (wash sling) and Wednesday. During observation and interview on 10/21/24 at 2:24 p.m., R4's right side of her wheelchair seat and seat cushion had dried liquids, cereal ,and other unidentified dried food items. R4 stated did not like the chair being dirty and did not know last time it had been cleaned. During observation and interview on 10/22/24 at 1:18 p.m., nursing assistant (NA)-A confirmed R4's wheelchair was very dirty with dried cereal and other food items on and under the right side of the seat cushion. NA-A stated that there was a schedule for wheelchair cleaning and the overnight staff cleaned them per the schedule, however it was the responsibility of all staff to ensure the resident's wheelchairs were clean. NA-A stated that if a dirty wheelchair was identified by staff, that staff should clean it or ensure it was cleaned right away. During observation on 10/23/24 at 1:00 p.m., R4 was in the dining room eating lunch in her wheelchair. The right corner of the seat appeared dirty with dried food items. During observation on 10/23/24 at 1:58 p.m., R4's wheelchair was still extremely dirty with the same dried liquids, cereal, and other unidentified food items. During interview on 10/23/24 at 2:06 p.m.,	F 584	Weekly checks by the Director of Nursing (DON) Performance Tracking: Quarterly compliance reports will be reviewed at Quality Assurance and Performance Improvement (QAPI) meetings. Completion Date: November 20th 2024	

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F 584	Continued From page 4 registered nurse (RN)-A stated wheelchairs were cleaned weekly on the resident's bath day per the schedule but should be cleaned on an as needed basis as well. RN-A stated staff were expected to clean the wheelchairs immediately when identified as dirty, and should not just wait for the weekly scheduled washing. RN-A stated R4's wheelchair could get pretty dirty during meals due to the way she ate and leaned to the right side. During interview on 10/23/24 at 2:10 p.m., director of nursing (DON) stated wheelchairs were scheduled to be cleaned weekly on the resident's bath day, but the expectation was for staff to maintain a clean wheelchair throughout the week. DON further stated R4's wheelchair could get pretty dirty during meals and should probably be on a twice a week schedule for cleaning. Facility policy Infection Control Wheelchair Cleaning dated October 2015, indicated, "Wheelchairs will be maintained in a clean, hygienic condition."	F 584		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		11/20/24

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F 695	Continued From page 5 Based on observation, interview, and document review, the facility failed to ensure oxygen therapy was administered as ordered and maintained appropriately for 1 of 1 resident (R16) reviewed for respiratory services. Findings include: R16's admission Minimum Data Set (MDS) dated 9/25/24, indicated R16 had moderately impaired cognition and required assistance with many activities of daily living (ADLs). The MDS indicated R16 required oxygen therapy and had diagnoses including respiratory failure, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), dementia, and anxiety. R16's care plan dated 9/19/24, indicated R4 had an alteration in respiratory status related to COPD, respiratory failure, and CHF and required the use of oxygen. The care plan instructed staff to ensure R16 had a full portable oxygen tank prior to leaving his room for meals and activities and to ensure oxygen was delivered via nasal cannula as ordered. R16's provider order dated 10/16/24 indicated, "oxygen 4lits [liters] continuous. Can increase to 6lits [liters] PRN [as needed] to keep sats [blood oxygen saturation level] above 90%." R16's October 2024 treatment administration record (TAR) indicated, "Fill and check portable liquid and O2 [oxygen] tank supply sufficiency every shift and as frequently as needed depending on liter flow rate ...Tubing and canula in plastic bag and hang appropriately when not in use."	F 695	1. Immediate Correction When staff was made aware, oxygen was initiated for resident and oxygen tubing was discarded and replaced with new equipment. Resident R16's chart was updated to Q hourly checks for three days to ensure oxygen was on, and portable tank was full. Updated PCC for all residents requiring oxygen with scheduled weekly changing of oxygen tubing and nebulizer kits. 2. Policy Reviewed All oxygen policies were reviewed: "Oxygen E-Tank," Oxygen Liquid," and "Oxygen Equipment Care and Maintenance Policy." No changes were made. 3. Staff Training All nursing staff were educated through our Relias education system regarding safe delivery of oxygen. 4. Ongoing Compliance Director of Nursing or designee will do random twice weekly checks for four weeks and then monthly until substantial compliance is maintained. All audit results will be reviewed at quarterly QAPI. Completion Date: November 20th 2024	

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F 695	Continued From page 6	F 695		

R16's care sheet dated 10/22/24, instructed staff to "Fill portable O2 tank before leaving room for meals" and to "help with O2 tubing."

During observation and interview on 10/21/24 at 2:38 p.m., R16 was in his room sitting in the recliner but still receiving oxygen via nasal cannula through the portable tank hanging on the back of his wheelchair. The level of O2 in the portable tank was on the lowest edge of green indicating very low or almost empty. R16's oxygen concentrator was off and sitting next to the recliner. The tubing connected to the concentrator was undated and laying on the floor between the recliner and the bathroom. R16 stated he did not know when the staff last checked or filled the portable tank or changed the O2 tubing.
During observation on 10/22/24 at 9:49 a.m., R16 was sitting in common area with several other residents waiting for an exercise activity to begin. R16 had O2 on through nasal cannula connected to a portable tank. The level in the tank was again at the lowest limit of the green indicator, appearing very low.

During observation on 10/22/24 at 11:56 a.m., R16 was in his room sitting in the recliner. He was receiving oxygen via nasal cannula connected to the portable tank hanging on his wheelchair. The O2 level indicator now in the red indicating the tank was almost empty or empty. The concentrator was next to him, turned off and tubing lying on the floor.

During observation on 10/22/24 at 12:04 p.m., R16 self-propelled out into the hallway. Nursing assistant (NA)-A walked by and told R16 he would assist him to lunch in a minute and would

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"fix" his oxygen. At 12:06 p.m., NA-A adjusted R16's nasal cannula and wheeled R16 to the dining room. NA-A did not check the level of oxygen in the portable O2 tank.

During observation on 10/22/24 t a12:59 p.m., licensed practical nurse (LPN)-A pushed R16's wheelchair out of the dining room into the hallway and encouraged R16 to self-propel back to his room. LPN-A did not check the portable tank. Director of nursing (DON) approached R16 and offered to assist him back to his room. R16 declined. DON did not check R16's portable tank. R16 self-propelled approximately 60 feet to his room.

During observation and interview on 10/22/24 at 1:38 p.m., unidentified hospice music therapist left R16's room after 30 minutes of music therapy. R16 was sitting in his room in his wheelchair and was not wearing his nasal cannula which was hanging off the arm of the wheelchair. R16 stated he thought the tank was empty and checked the nasal cannula confirming no O2 flow. R16 stated he could not remember the last time staff checked or filled the portable tank.

During observation on 10/22/24 at 1:45 p.m., R16 was standing in the hallway inquiring about the upcoming activities. NA-B identified R16 standing unassisted and escorted him back into his room and into his wheelchair. NA-B asked if R16 needed anything from her, he declined, and she left the room. NA-B did not address R16's oxygen and did not place R16 back on the nasal cannula.

During observation and interview on 10/22/24 at 1:50 p.m., LPN-A stated nurses were responsible

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F 695	Continued From page 8 for oxygen therapy maintenance. LPN-A stated her practice was to round at the start of the shift to ensure O2 was on as ordered and tubing was maintained appropriately. LPN-A further stated portable tanks were supposed to be checked by any staff prior to placing a resident on the tank and prior to leaving the room. LPN-A entered R16's room and identified R16 without his nasal cannula in place. LPN-A immediately placed R16 on O2 via the concentrator. LPN-A stated R16 should be on his concentrator when in his room and that all staff were responsible for ensuring he was wearing the nasal cannula and on the concentrator when in his room. LPN-A confirmed the portable tank was empty and also that the concentrator tubing should not be lying on the floor. LPN-A replaced the portable tank with a full one, refilled the water on the concentrator humidifier, and replaced the concentrator tubing with new tubing. During interview on 10/23/24 at 8:15 a.m., registered nurse (RN)-A stated staff should always check the portable O2 tanks when the resident was placed on the tank and each time prior to leaving the room. RN-A stated the resident should be on the concentrator when they were in their room rather than the portable to conserve the oxygen in the portable tank. RN-A stated R16 was on 4 liters of O2 and could go through a portable tank pretty quickly and checking his tank prior to leaving the room was very important. RN-A further stated O2 tubing should not be lying on the floor when not in use. During interview on 10/23/24 at 12:01 p.m., DON stated it was the nurse's responsibility to ensure oxygen therapy was maintained per provider orders. DON stated residents should be on the	F 695		

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F 695	Continued From page 9 O2 concentrator when in their room and that the portable tank should be checked and full when the resident leaves their room and the expectation for any staff to check the portable tank prior to the resident leaving his room. DON further stated O2 tubing should not be lying on the floor when not in use for infection control. Facility policy Oxygen Administration dated February 2017, indicated nurses should "check each shift, or more frequently as appropriate, the O2 tank to ensure appropriate flow and sufficient O2 is present in tank." The policy further indicated, "Tubing, humidifier and nasal cannula, mask or other apparatuses to administer oxygen should be placed in a plastic bag when not in use." Facility policy Oxygen Equipment Care and Maintenance dated October 2011, indicated, "Tubing is not to touch the floor ...Curl tubing and place, with mask/cannula, in a plastic bag and hang appropriately ...On each shift the nurse should monitor liter flow of oxygen."	F 695		

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	245637	A. BUILDING **01 - PRESBYTERIAN HOMES OF COTTAGE GROVE** B. WING _____	**10/23/2024**

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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/23/2024. At the time of this survey, NORRIS SQUARE 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 18 NEW 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. Healthcare Fire Inspections	K 000		

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

Electronically Signed | 11/07/2024

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

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K 000	Continued From page 1 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. NORRIS SQUARE is a 2 story building with no basement. Norris Square was constructed in 2018 and was determined to be of Type II(222) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, and spaces open to the corridors that are monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. There are smoke alarms in resident rooms that are interconnected to the nurse call system. The facility has a capacity of 39 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 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 and less than 100 square feet) g. Combustible Storage Rooms/Spaces	K 321		12/6/24

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NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

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K 321	Continued From page 3 (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.2.1, 18.3.6.3.11, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/23/2024 between 09:15 AM and 1:15 PM, it was revealed by observation that the following was found: 1. The main trash chute collection room on 1st floor double doors will not shut and latch. 2. The trash chute door at bottom of shaft doest not have a fusible link in the chain that holds the door open. 3. The storage / sprinkle riser room has an 1 foot and 3 foot opening that has several conduit pipes going through the ceiling that is filled with a orange in color spray foam. No documentation could be provided for proper fire-stopping rating. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 321	1. The facility will maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.2.1, 18.3.6.3.11, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. Specifically, the trash chute door on the main level will be repaired to close and latch properly on or before December 6th, 2024. This trash chute door, together with all trash chute doors in this facility, will be added as a monthly inspection task to the Electronic Work Order System (EWOS) existing monthly fire door inspection task. The Regional Engineering Manager (REM) will be responsible for adding this task on or before December 6th, 2024. The Environmental Services Director (ESD) will be responsible for ensuring this monthly task is completed promptly. The REM will ensure the tasks have been completed during the document review portion of the Annual Facility Review. (AFR) 2. The facility will maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.2.1, 18.3.6.3.11, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. To comply, The fusible link at the bottom of the trash chute will be replaced on or before December 6th, 2024. Inspecting the fusible link will be added as a monthly inspection task to the Electronic Work	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING **01 - PRESBYTERIAN HOMES OF COTTAGE GROVE** B. WING _____	**10/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

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K 321	Continued From page 4	K 321	Order System (EWOS) existing monthly fire door inspection task. The Regional Engineering Manager (REM) will be responsible for adding this task on or before December 6th, 2024. The Environmental Services Director (ESD) will be responsible for ensuring this monthly task is completed promptly. The REM will ensure the tasks have been completed during the document review portion of the Annual Facility Review. (AFR) 3. The gaps in the fire barrier wall in the storage/sprinkler room will be fire stopped with code approved fire retardant sealant 3M Fire Barrier Sealant 25WB Plus on or before December 6th, 2024. The ESD and the REM will be responsible for ensuring these gaps are properly sealed. The ESD will conduct an inspection of gaps in all fire barrier structures in hazardous/storage spaces by December 6th, 2024. The REM will inspect all spaces for fire barrier gap compliance during the AFR.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke	K 324		12/6/24

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K 324	Continued From page 5 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 18.7.6, 4.6.12, 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 widespread impact on the residents within the facility. Findings Include: On 10/23/2024 between 09:15 AM and 1:15 PM, it was revealed by a review of available documentation that inspection documentation for 1st and 2nd floor kitchen hood fire suppression system was not completed with-in the last 6 months. Last inspection was completed on 04/18/2024 by Summit Fire Protection. An interview with the Director of Maintenance, Administrator and Administrator Intern verified this deficient findings at the time of discovery.	K 324	The facility will test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 18.7.6, 4.6.12, 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. The kitchen hoods on the first and second-floor kitchens will be inspected on or before December 6th, 2024. The ESD will be responsible for contracting with a licensed fire alarm system provider to conduct this inspection. A task will be added to the EWOS by the REM on or before December 6th, 2024 December 6th, 2924 to prompt the timely scheduling of this biannually required inspection. The REM will review this biannual documentation during the documentation review portion of the AFR.	
K 712	Fire Drills	K 712		12/6/24

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K 712 SS=F	Continued From page 6 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. 18.7.1.4 through 18.7.1.7 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 18.7.1.4 and 18.7.1.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/23/2024 between 09:15 AM and 1:15 PM, it was revealed by a review of available documentation that the following was found: 1. The 3rd quarter, 3rd shift drill was not conducted, 2. Three of the 3rd shift drills were conducted between 12:30 AM to 01:25 AM 3. No times were record for the 3rd shift, stating that the next day the monitoring company siginal was tested and verified An interview with the Director of Maintenance, Administrator and Administrator Intern verified	K 712	1. The facility will conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 18.7.1.4 and 18.7.1.7. on or before December 6th, 2024. A fire drill task schedule for the current year will be added to the EWOS. The REM and the ESD will be responsible for adding these drills into the EWOS task list on or before December 6th, 2024. 2. Fire Drills will 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 ESD will be responsible for ensuring these scheduled drills are completed on time. The REM will ensure the fire drills were conducted as scheduled by reviewing fire drill reports during the document review portion of the AFR. The REM and the ESD will be responsible for entering the fire drill schedule for subsequent years into the	

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K 712	Continued From page 7 these deficient findings at the time of discovery.	K 712	EWOS task list. 3. The standard fire drill report form will be used for all drills, simulated or not. The ESD will be responsible for ensuring the fire drill report forms contain all the required information, including the time the drill was conducted. The REM will inspect the fire drill report forms for compliance during the document review portion of the AFR.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 29, 2024

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

Re: State Nursing Home Licensing Orders
Event ID: ICJ811

Dear Administrator:

The above facility was surveyed on October 21, 2024 through October 24, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33301	A. BUILDING: _____ B. WING _____	C 10/24/2024

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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 10/21/24 through 10/24/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H56379702C (MN107644). No licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state	2 000		

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2 000	Continued From page 2 form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clean and maintain a resident's wheelchair for 1 of 1 resident (R4) reviewed for safe, clean, and homelike environment. Findings include: R4's quarterly Minimum Data Set (MDS) dated 9/4/24, indicated R4 was cognitively intact, was dependent on staff for mobility in a manual wheelchair, required partial/moderate assistance with transfers and set up/clean up assistance with meals. The MDS indicated R4 would have a loss of liquids/solids from mouth when eating or	21695	Corrected	11/20/24

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21695	Continued From page 3 drinking. R4's diagnoses included progressive supranuclear ophthalmoplegia (a condition affecting the movement of the eyes), dysphagia (a condition affecting one's speech), and anxiety. R4's care plan dated 9/6/24, indicated R4 had an activities of daily living (ADL) self-care performance deficit and instructed staff to assist as needed with dressing, grooming, eating, bathing, and mobility. The care plan instructed staff to place a clothing protector on shirt and lap during meals. R4's clinical nutrition assessment dated 8/29/24, indicated R4 required an extra clothing protector for lap protection from spills and that R4 had a loss of food/liquids from mouth. R4's nursing assistant care sheet (south unit) dated 10/22/24, indicated R4's bath day was Monday mornings and laundry was pulled from R4's room on Sunday evenings. The south unit laundry/wheelchair cleaning schedule dated 6/13/24, indicated R4's room number was listed on Sunday (wash sling) and Wednesday. During observation and interview on 10/21/24 at 2:24 p.m., R4's right side of her wheelchair seat and seat cushion had dried liquids, cereal ,and other unidentified dried food items. R4 stated did not like the chair being dirty and did not know last time it had been cleaned. During observation and interview on 10/22/24 at 1:18 p.m., nursing assistant (NA)-A confirmed R4's wheelchair was very dirty with dried cereal and other food items on and under the right side of the seat cushion. NA-A stated that there was a	21695		

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21695	Continued From page 4 schedule for wheelchair cleaning and the overnight staff cleaned them per the schedule, however it was the responsibility of all staff to ensure the resident's wheelchairs were clean. NA-A stated that if a dirty wheelchair was identified by staff, that staff should clean it or ensure it was cleaned right away. During observation on 10/23/24 at 1:00 p.m., R4 was in the dining room eating lunch in her wheelchair. The right corner of the seat appeared dirty with dried food items. During observation on 10/23/24 at 1:58 p.m., R4's wheelchair was still extremely dirty with the same dried liquids, cereal, and other unidentified food items. During interview on 10/23/24 at 2:06 p.m., registered nurse (RN)-A stated wheelchairs were cleaned weekly on the resident's bath day per the schedule but should be cleaned on an as needed basis as well. RN-A stated staff were expected to clean the wheelchairs immediately when identified as dirty, and should not just wait for the weekly scheduled washing. RN-A stated R4's wheelchair could get pretty dirty during meals due to the way she ate and leaned to the right side. During interview on 10/23/24 at 2:10 p.m., director of nursing (DON) stated wheelchairs were scheduled to be cleaned weekly on the resident's bath day, but the expectation was for staff to maintain a clean wheelchair throughout the week. DON further stated R4's wheelchair could get pretty dirty during meals and should probably be on a twice a week schedule for cleaning. Facility policy Infection Control Wheelchair	21695		

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21695	Continued From page 5 Cleaning dated October 2015, indicated, "Wheelchairs will be maintained in a clean, hygienic condition." SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a wheelchair program was maintained per scheduled or on an as needed basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure wheelchair cleaning is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		