



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 2, 2024

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

RE: CCN: 245341
Cycle Start Date: February 14, 2024

Dear Administrator:

On March 13, 2024, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink that reads 'H. Zahler'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 27, 2024

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

RE: CCN: 245341
Cycle Start Date: February 14, 2024

Dear Administrator:

On February 14, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by May 14, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 14, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

Centracare Health System-Sauk Centre Nursing Home

February 27, 2024

Page 4

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

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

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

Feel free to contact me if you have questions.

Sincerely,



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

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

PRINTED: 02/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2024
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NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 425 N ELM STREET SAUK CENTRE, MN 56378
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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
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E 000	Initial Comments On 2/12/2024 through 2/14/2024, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/12/2024 through 2/14/2024, 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		2/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/28/2024
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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: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 425 N ELM STREET SAUK CENTRE, MN 56378		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	<p>Continued From page 1</p> <p>The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the completed quarterly Minimum Data Set (MDS) was accurately coded to reflect hospice services for 1 of 1 resident (R10) reviewed for MDS' accuracy.</p> <p>Findings include:</p> <p>The CMS Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified each section of the MDS along with various instructions how to code and/or complete them. The section labeled, "Section O: Special Treatments, Procedures, and Programs," listed directions to record any special treatments or programs the resident received during the specified time period (i.e., assessment reference date; ARD). This included, " ... Hospice Care," and outlined, "Code residents identified as being in a hospice program ... where any array of services is provided for the palliation and management of terminal illness ..."</p> <p>R10's quarterly MDS dated 11/17/23, identified diagnoses included non-Alzheimer's Dementia, diabetes mellitus, end stage renal disease and hypertension (elevated blood pressure). The MDS failed to identify R10 received hospice care in section O- Special Treatments and Programs.</p> <p>Face sheet printed 2/14/24, identified R10 was admitted to hospice services on 8/8/23.</p> <p>During an interview on 2/14/24 at 9:45 a.m., registered nurse (RN)-A verified he had reviewed</p>	F 641	<p>Deficient practice on one resident was found d/t incorrect MDS submission. This was corrected the day of finding. MDS coordinator modified the MDS and resubmitted, same day deficient practice was found.</p> <p>MDS Coordinator will keep an ongoing updated Matrix Spreadsheet to ensure that all resident information is accurate and up to date along with an Audit.</p> <p>Weekly Audits on all MDS submissions will be completed until all current Hospice Residents have had an MDS submission and there are no errors found in the Audit.</p> <p>Deficiency was corrected day that it was found by the Department of Health and MDS was resubmitted.</p>	

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

PRINTED: 02/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 425 N ELM STREET SAUK CENTRE, MN 56378		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	<p>Continued From page 2</p> <p>R10's MDS (dated 11/17/23) and stated hospice care should have been coded adding, "That was a mistake."</p> <p>During an interview on 2/14/24 at 12:10 p.m. the director of nursing (DON) stated R10 was on hospice for some time. The DON stated MDS assessment accuracy was important because it drove reimbursement rates, staffing needs and was basis for everything long term care related.</p> <p>The facility policy Minimum Data Set, Management of, Long Term Care policy, revised 3/2023, identified the purpose to ensure the Minimum Data Set (MDS) is accurately and comprehensively completed. All MDS assessments and records will be completed and electronically encoded into the facility's electronic medical record and transmitted to the state database in accordance with current regulations. OBRA tracking records and assessments will be completed as defined per the RAI manual.</p>	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - EAST ADDITION B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2024
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NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 425 N ELM STREET SAUK CENTRE, MN 56378
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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
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/14/2024. At the time of this survey, Centracare Health System-Sauk Centre Nursing Home Building 02 was found 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 Occupancies and the 2012 edition of NFPA 99, the Health Care Facilities Code.</p> <p>Centracare Health System-Sauk Centre Nursing Home Building 02 is a 1-story building addition with no basement, and is fully fire sprinkler protected constructed in 2022 and completed in 2023. Construction type is determined to be Type II (000) and has an attic space that has a dry sprinkler system.</p> <p>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and is monitored for automatic fire department notification.</p> <p>The facility has a capacity of 60 beds and had a census of 35 at the time of the survey.</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is MET.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

03/05/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NURSING HOME MAIN B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2024
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NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 425 N ELM STREET SAUK CENTRE, MN 56378
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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
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/14/2024. At the time of this survey, Centracare Health System-Sauk Centre Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>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.</p> <p>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.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/05/2024
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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: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NURSING HOME MAIN B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 425 N ELM STREET SAUK CENTRE, MN 56378		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>Continued From page 1</p> <p>PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> <p>Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR</p> <p>By email to: FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 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. <p>Centracare Health System-Sauk Centre Nursing Home building 03 is a complete remodel and is a 2-story building addition with no basement, remodel of 27 resident rooms, and is fully fire sprinkler protected constructed in 2022 and completed in 2023. Construction type is determined to be Type II (111). This building</p>	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NURSING HOME MAIN B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 425 N ELM STREET SAUK CENTRE, MN 56378		
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K 000	Continued From page 2 consists of 3 smoke compartments. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and is monitored for automatic fire department notification. The facility has a capacity of 60 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 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 This REQUIREMENT is not met as evidenced by:	K 351		2/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NURSING HOME MAIN B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2024	
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 425 N ELM STREET SAUK CENTRE, MN 56378		
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K 351	Continued From page 3 Based on observation and staff interview, the facility failed to install the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.5.1 and 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.15.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/14/2024 between 9:00 and 11:00 AM, it was revealed by observation that the elevator equipment room did not have a sprinkler head installed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 351	Maintenance contacted a qualified contractor to add sprinkler head to the Elevator Equipment room. Summit Fire Protection added sprinkler head to the Elevator Equipment room on 2-26-2024. Departments tours will be conducted by Maintenance, EVS, Infection Control and the affected Department on semi-annual basis. A qualified contractor will conduct the annual inspection of the sprinkler to ensure that all areas are fully covered with fire suppression.	
K 374 SS=B	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required.	K 374		2/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NURSING HOME MAIN B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM-SAUK CENTRE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 425 N ELM STREET SAUK CENTRE, MN 56378		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	<p>Continued From page 4 18.3.7.6, 18.3.7.7, 18.3.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.7.8 and 8.5.4.1. These deficient findings could have a patterned impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 02/14/2024 between 9:00 and 11:00 AM, it was revealed by observation that the fire barrier door by rooms 101 and 102 did not close and latch, and the smoke barrier door by room 117 did not close completely leaving a gap between the two door leaves.</p> <p>An interview with the Maintenance Director verified these deficient findings at the time of discovery.</p>	K 374	<p>The fire barrier door located by rooms 101 and 102 the door closer has been adjusted by Maintenance for proper latching.</p> <p>A TMS work order is in place to ensure the testing of fire barrier and smoke barrier doors annually. Department tours will be completed by Maintenance, EVS, EP and Infection Prevention Semi-annually.</p> <p>Maintenance has contacted the appropriate contractors to resolve the air flow issues causing the smoke doors to be ajar. A semi-annual inspection will include the operation of the smoke doors throughout the facility to ensure the doors close on a fire alarm. 5/1/24</p>	