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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KDJW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**
2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **FIRST CARE LIVING CENTER**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

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

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, Unit Supervisor 12/27/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/27/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/06/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 27, 2021

CMS Certification Number (CCN): 245512

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

Dear Administrator:

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

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

Effective November 23, 2021 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 27, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: CCN: 245512
Cycle Start Date: September 30, 2021

Dear Administrator:

On October 27, 2021, we notified you a remedy was imposed. On November 23, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 23, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 26, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 27, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 26, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 23, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KDJW

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Facility ID: 00461

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(L3) **FIRST CARE LIVING CENTER**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/30/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE - NE II 11/29/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/03/2021 (L20)

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

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

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 27, 2021

Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, MN 56542

RE: CCN: 245512
Cycle Start Date: September 30, 2021

Dear Administrator:

On September 30, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 26, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 26, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 26, 2021.

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by November 26, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, First Care Living Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 26, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 March 30, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

(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 9/27/21 through 9/30/21, 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 9/27/21 through 9/30/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5512044C (MN75842). 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 that substantial compliance with the regulations has been attained.	F 000		
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580		11/11/21

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

Electronically Signed | 11/05/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

(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 580 SS=D	Continued From page 1 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

(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 580	Continued From page 2 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to notify the medical provider of blood sugar or weights outside of identified parameters for 2 of 2 residents (R3, R11) reviewed for medication management and had identified parameters. Findings include: R3's significant change Minimum Data Set dated 7/3/21, identified R3 was cognitively intact and included diagnoses of diabetes mellitus, heart failure and hypertension. Further, R3 received insulin injections daily. R3's care plan dated 9/21/21, identified R3 required additional monitoring due to diabetes and directed staff to monitor for symptoms of hyperglycemia (blood glucose >140 milligram/deciliter (mg/dl) including increased thirst, urination, and appetite followed by decreased appetite, nausea and vomiting and if R3's blood glucose was high to follow the MD (physician) orders for medication administration, recheck blood sugar as needed and update the provider as needed.	F 580	F580 D First Care Living Center ensures that staff will immediately inform the resident; consult with the resident□s physician, and notify, consistent with his or her authority, the resident representative when there is: A) Significant change in the resident□s physical, mental, or psychosocial status in either life-threatening conditions or clinical complications. B) Need to alter treatment due to adverse consequences, or to commence a new form of treatment. A. Review of policy: Resident Change of Condition Assessment Preventing and Detecting Adverse Medication Consequences. Review of policy: Physician, Resident, Resident Representative Notification. B. RN assessment of R3□s medical condition and medical records 10/1/21. Notification to Primary Physician who revised the sliding scale orders to addend novolog sliding scale insulin to have	

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F 580	Continued From page 3 R3's Physician Order Report dated 8/28/21 - 9/28/21, included the following orders: -Accu-check (blood glucose test) QID [four times per day], 6:30 a.m.-10:00 a.m., 11:00 a.m.-2:00 p.m., 2:30 p.m.-5:00 p.m., 6:30 p.m.-10:00 p.m. The order start date was 4/30/21. -If blood sugar was greater than 400, call MD. The order start date was 5/3/21. R3's Medication Administration Record (MAR) identified the following: -7/1/21-7/31/21, R3's blood glucose level on 7/15/21 for the 6:30 p.m.-10:00 p.m. reading was 401 mg/dl. - 8/1/21-8/31/21, R3's blood glucose level on 8/27/21 for the 6:30 p.m.-10:00 p.m. reading was 405 mg/dl. -9/1/21-9/30/21, R3's blood glucose level on 9/23/21 for the 11:00 a.m.-2:00 p.m. reading was 412 mg/dl and the blood glucose level on 9/26/21 for the 6:30 p.m.-10:00 p.m. reading was 402 mg/dl. R3's medical record lack evidence of notification of R3's physician and follow-up related to the elevated blood glucose levels. On 9/30/21, at 11:10 a.m. R3 was well groomed, seated in a wheelchair in his room and stated his diabetes had been "pretty good lately". During interview on 9/30/21, at 11:35 a.m. licensed practical nurse (LPN)-A stated if a resident had a blood glucose reading greater than 400 they would need to notify the physician and	F 580	nursing to give 14 units if blood sugar is 401-450 and give 16 units of novolog insulin if blood sugar is >450. Review of blood sugar values monthly on Physician rounds. C. RN review and assessment of all residents to identify those with perimeters for sliding scale blood sugars to ensure parameters were followed and documentation is in place. RN identified one other resident with sliding scale Blood Sugar orders to notify provider if BS>400. Audits of this resident□s blood sugars show that no Blood Sugars are out of range. D. DON or her designee to perform daily audits of documentation in Electonic Medication Record (EMR) x 4 weeks of all orders for blood sugar sliding scale parameter compliance, to ensure parameters were followed and documentation is in place. Medication Parameters Audit folder will be kept in the Medication Room for access to all nursing for weekend audits & as needed monitoring. E. All new residents and/or new orders for sliding scale blood sugar monitoring will be added to the Medication Parameter folder for daily audits x 4 weeks. F. RN assessment of R11□s medical condition and medical records on 10/1/21. Primary Physician notified and no changes to R11□s orders. Daily weight before eating or drinking in morning.	

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F 580	Continued From page 4 also document in a progress note the physician was notified. During interview on 9/30/21, at 11:45 a.m. registered nurse (RN)-A stated staff should call the on-call or primary physician for a blood glucose reading over 400. There should also be documentation of the physician notification in a progress note in the resident's chart. RN-A reviewed R3's electronic chart and stated there were no comments noted on the MAR, nor were there progress notes regarding the elevated blood glucose readings or notification of R3's physician for the 7/15, 8/27, 9/23 or 9/26 results and she would have expected the nurse to notify the physician as directed in the orders and document the follow up. R11's quarterly MDS dated 7/20/21 identified R11 was cognitively intact and included diagnoses of heart failure, hypertension and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). The MDS also identified R11 received diuretic medication daily. R11's care plan dated 7/28/21, identified R11 had a risk of shortness of breath, increased edema, and fluctuation in weight related to congestive heart failure and directed R3 required daily weights. Staff were to attempt to weigh at the same time each day, before eating or drinking if possible. Call the Heart Failure Clinic for a weight gain of three pounds (lbs) overnight, gain of 5 lbs or loss of 10 lbs in a week. R11's Physician Order Report dated 8/28/21 - 9/28/21, included the following orders -furosemide 40 mg once a morning for hypertensive heart disease with heart failure. The	F 580	Special Instructions: Call Heart failure Clinic for weight gain of 3 lbs overnight, gain of 5lbs, or loss of 10 lbs in a week. G. RN review and assessment of all residents with parameters for weights, edema, or shortness of breath, to identify these residents to ensure parameters are followed and documentation is in place. RN identified one other resident with parameters to give PRN Lasix 40mg daily if daily weight gain over 3# or weekly wt >6#. H. DON or her designee to perform daily audits of documentation in EMR of all residents with parameters for weights, edema, or shortness of breath to ensure compliance of parameters are followed and documentation in place x 4 weeks. Medication Parameters Audit folder will be kept in the Medication Room for access to all nursing for weekend audits and as needed monitoring. I. All new residents and/or new orders for monitoring of weights, edema, or shortness of breath will be added to daily auditing x 4 weeks in the Medication Parameters Audit Folder. J. Pharmacy Consultant audit of all Physician orders with parameters on October 13, 2021, and Pharmacy Consultant to continue to audit blood sugars and Edema/weights parameters monthly. K. Education provided on policy and	

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F 580	Continued From page 5 order start date was 5/11/21. -spironolactone 12.5 mg once a morning for unspecified systolic (congestive) heart failure. The order start date was 5/11/21. -Daily weight before eating or drinking in morning. Special instructions: Call heart failure clinic for weight gain of 3 lbs overnight, gain of 5 lbs or loss of 10 lbs in a week. The order start date was 5/19/21. During observation on 9/29/21 at 7:01 a.m. NA-B provided morning cares for R11 including putting on his socks and shoes. No extremity edema observed. R11's weights documented on the Medication Administration Record dated 8/8/21-9/7/2, identified the following: -8/8/21: 195.4 lbs -8/9/21: 203.6 lbs (8.2 lb gain in 1 day) -8/10/21: 204.2 lbs (8.8 lb gain in 2 days) -8/11/21: 206.8 lbs (11.4 lb gain in 3 days) -8/19/21: 206.8 -8/20/21: 210.6 (3.8 lb gain in 1 day) -9/1/21: 201.6 -9/6/21: 207 (5.4 lbs in 5 days) -9/7/21: 208.2 (6.6 lbs in 6 days) R11's medical record lacked evidence the medical provider (heart failure clinic) was notified of the weight gains as ordered. During interview on 9/30/21, at 11:29 a.m. NA-A stated the NA's take the resident weights and let the cart nurse know the result During interview on 9/30/21, at 11:30 AM LPN-B stated didn't usually work the day shift; however, she entered the daily weight into the computer	F 580	procedures to all nursing and trained medication aides at staff meetings on 10/13/21 and 11/3/21. Education included to immediately inform the resident, consult with resident□s physician, and notify the residents legal representative when there is a significant change in the resident□s physical, mental, or psychosocial status or a need to alter treatment significantly. Document all occurrences and notifications in the progress notes. Documentation by signature that they have received copies of the policies and understand the information. L. Staff not attending were provided written copies of policies and procedures for Resident Change of Condition Assessment Preventing and Detecting adverse Medication Consequences and Physician, Resident, Resident Representative Notification. Documentation by signature the understanding of this information, prior to their next shift. Protocol included with all new employee orientation. M. QAPI monthly will review audit documentation of monitoring parameters for blood sugars, weights, edema, shortness of breath, etc. QAPI will determine if compliance is met or need for more auditing. N. Review of completion date 11/11/21.	

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F 580	Continued From page 6 and when she did so, checked the previous weight from the day before. There was a parameter for R11's weight to monitor for a weight gain of 3 lbs overnight or 5 lbs over three days. She didn't have to worry because R11's weight was down today. If his weights were up, she would have let the RN know. During interview on 9/30/21, at 12:07 p.m. RN-A reviewed R11's weights in the electronic medical record from August to present and stated she was not notified of any weight gains. She was not notified of the weight gains on 8/9, 8/10, 8/11, 9/6 or 9/7 and only remembered calling the heart failure clinic for him once and it was not recently. There was no documentation of follow up with the heart failure clinic as required and she would notify them today. Her expectation would have been the heart failure clinic should have been notified as defined in the order. The Physician, Resident Representative Notification Policy revised 6/14/21, directed Essentia Living Center (ELC) would immediately inform the resident; consult with the resident's physician; and notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status or a need to alter treatment significantly.	F 580		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		11/11/21

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F 677	Continued From page 7	F 677		

by:
Based on observation, interview, and document review, the facility failed to provide routine oral care for 1 of 2 residents (R14) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.

Findings include:

R14's quarterly Minimum Data Set (MDS) dated 7/27/21, identified R14 had moderate cognitive impairment and required extensive assistance with personal hygiene. Diagnoses included Parkinson's disease, dementia and chronic obstructive pulmonary disease (COPD).

R14's dental Care Care Area Assessment (CAA) dated 5/7/21, identified R14 did not have her own natural teeth and used full upper and lower dentures.

R14's care plan dated 8/20/21, indicated R14 was edentulous (without natural teeth) and used full upper and lower dentures. The care plan directed staff to assist R14 to brush her dentures and swab mouth twice daily and as needed.

The nursing aide North report sheet updated 9/16/21, identified R14 required assist of one every three hours for toileting and repositioning. The report sheet did not direct staff regarding R14's oral care needs.

On 9/29/21, at 7:51 a.m. nursing assistant (NA)-A assisted R14 with her morning cares. NA-A wheeled R14 into the bathroom to brush her teeth. NA-A applied toothpaste to R14's toothbrush and encouraged R14 to brush her teeth. NA-A did not attempt to remove R14's

F677 D

First Care Living Center ensures that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal hygiene, and oral hygiene.

A. Review of policy: Oral Health Program

B. Implementation of Standard Work for Denture Care, which describes in detail the required steps for proper denture care.

C. NA-A interviewed for RCA of failure to complete oral cares per care plan. Education for Oral Health Care delivery in LTC completed on October 14, 2021. Oral Care audit by observation for NA-A on 10/21/21, 11/1/21, and 11/4/21. NA-A audited to ensure she was able to access the Matrix care profile.

D. RN assessment and review of R14□s oral status and care plan goals for daily oral cares and interventions identified to ensure adequate oral hygiene practices. Care Plan and Matrix care profile updated to reflect R14□s oral care needs. The Matrix care profile is an electronic reference of care plan approaches for NARs to reference.

E. RN assessed, (reviewed with NARs and residents), and revised as necessary all residents□ oral status which was

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F 677	Continued From page 8 dentures nor did she encourage R14 to remove her dentures. NA-A stated resident dentures were removed for soaking at bedtime and R14 did not like to remove her dentures. R14 easily removed her dentures herself when asked. The bottom denture did have a small amount residual food and the top denture was encrusted with residual food particles. NA-A brushed and rinsed R14's dentures in the sink. NA-A did not swab R14's mouth before placing R14's dentures back into her mouth. During interview on 9/29/21, at 8:16 AM NA-A stated she thought R14 only had bottom dentures but did not remove the bottom dentures during oral cares and should have. R14's dentures should be removed at bedtime for soaking. Nursing assistants were able to determine what assistance a resident needed by using the electronic medical record or by reviewing the printed aide sheets; however, NA-A did not carry her aide sheet with her and kept it at the nurses' desk. During interview on 9/29/21, at 8:20 a.m. registered nurse (RN)-B provided a copy of the aide sheet. Further, the nursing assistants always had access to the resident electronic medical record by using the monitor in the resident room. R14 required assistance with brushing her dentures twice daily and as needed and the dentures should be brushed outside of the mouth. Additionally, dentures should be soaked at bedtime, but not every resident liked to do that. RN-B would address oral care with the nursing assistants. During interview on 9/30/21, at 10:55 a.m. RN-B stated residents had the right to refuse oral care	F 677	completed on 10/21/21. Care plan and Matrix care profile updated to reflect all residents current oral status, goals for daily oral cares identified, interventions in place to reflect individualized oral care needs and ensure adequate oral hygiene practices. F. Quarterly MDS assessment by RN Coordinators to assess & maintain accurate oral care planning, ensuring adequate information to NARs via the Matrix care profile. G. Education on Oral Health Program policy and procedures and Standard work for Denture Care provided at staff meetings on October 13th and 14th, and on November 3rd and 4th, 2021. Staff completed Oral Health Care Delivery in LTC. Documentation by signature that they have received and understand the information. Each staff member received copies of the Standard Work for Denture Care, read and sign that they comprehend procedure for caring for dentures. H. DON or her designee will audit by observation - compliance with oral care hygiene. One AM audit daily and one PM audit daily on each community (North and South communities) x 1 week, then one AM audit and on PM audit on each community weekly x 4 weeks. Random audits thereafter. I. QAPI monthly will review oral care audit documentation. QAPI will determine if compliance is met or need for more	

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F 677	Continued From page 9 or to remove their dentures; however, it was expected dentures to be brushed outside of the mouth. The facility policy Oral Health Program dated 9/30/13, identified the facility was to provide a comprehensive oral hygiene program for residents. The policy directed staff to provide oral cares to residents every morning and every evening. The policy did not direct staff on how to care for dentures.	F 677	auditing. J. Completion date 11/11/21	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of	F 849		11/11/21

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F 849	Continued From page 10	F 849		

the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical

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F 849	Continued From page 11 direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State	F 849		

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scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides

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FIRST CARE LIVING CENTER	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

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F 849	Continued From page 13 orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to communicate hospice care options to the resident and/or their representative when the facility contracted hospice agency failed to provide a timely admission for hospice services for 2 of 2 residents (R14, R1) reviewed for hospice. Findings include: R14's quarterly Minimum Data Set (MDS) dated 7/27/21, identified R14 had a moderately impaired cognition. Diagnoses included heart failure (HF), Parkinson's disease, dementia, and chronic obstructive pulmonary disease (COPD). The MDS did not identify R14 as receiving hospice or palliative (end of life) care. R14's nursing progress note dated 7/29/21, identified family member (FM)-A was updated regarding R14's recent Remeron (antidepressent and appetite stimulant) medication change due to R14 not eating as much and had more difficulty with communication due to progressing	F 849	F849 D First Care Living Center (FCLC) ensures each resident and /or their representative will be provided hospice care options if the facilities hospice agency has not provided timely admissions. FCLC may: A) arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices or B) assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer, and provide a timely admission to hospice. C) FCLC ensures to provide comfort care at the end of life that is reasonable and provides maximum comfort and quality of life to the resident and the resident family. A. R14 admission to Essentia Home Health and Hospice on 10/13/21 to optimize end-of □life services in the facility.	

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F 849	Continued From page 14 Parkinson's disease. FM-A verbalized understanding and staff asked if FM-A was interested in pursuing a hospice referral due to R14's disease progression. R14's care conference note dated 8/3/21, identified a interdisciplinary team (IDT) met with FM-A. The IDT explained R14's primary care provider (PCP) had recommended a hospice referral due to R14's disease progression. The IDT explained the purpose and benefit of hospice and R14's care would be centered around comfort rather than pursuing extraordinary measures such as an emergency room or hospital visits. FM-A verbalized understanding and agreed with the hospice referral. A referral was sent to hospice. R14's physician orders dated 8/14/21, included a hospice referral due to Parkinson's disease that was ordered on 8/3/21. R14's nursing progress note dated 8/19/21, identified R14 was evaluated by her PCP during routine rounds. No changes were made in R14's medication or treatments. The PCP reported hospice was in contact and planned to admit R14 to hospice soon. R14's care plan dated 8/20/21, did not include end of life care interventions or if R14 was receiving hospice or palliative care services. R14's Monthly High Risk Nutrition Assessment note dated 8/31/21, identified R14 had a significant weight loss of 32 lbs in 147 days. R14's diagnosis of Parkinson's impacted her nutritional status and R14 had a recent referral to hospice care. Staff were directed to continue to	F 849	B. R1 admission to Essentia Home Health and Hospice on 11/2/21 to optimize end-of-life services in the facility. C. RN MDS Coordinators assess the health status of all the residents quarterly and with change of condition. Quarterly and significant change care conferences with residents/resident representatives to discus any changes or imminent changes in a resident health concerns. The Physicians are updated with health condition changes, and they make the decision if a resident is a candidate for end of life measures/Comfort Care/ Hospice referrals. D. FCLC has adapted an Essentia Policy for Comfort Cares. This Policy includes the First Care Living Center Comfort Care Orders that will be individualized by the physician for each resident needing services in the event that Hospice services are unavailable. E. Education provided at AM huddle with RNs / Social Services/HUC leadership team on the Comfort care policy and Comfort care orders 10/8/21 and 11/5/21. F. Residents or resident representative may request Comfort Care as an option for end of life. Comfort Care will be given in accordance with the residents wishes as determined by his/her Advanced Directives and with the provider order for Comfort Care. Comfort Care orders will be written specific to the Resident.	

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F 849	Continued From page 15 monitor oral intakes, weight and vitals. R14's nursing progress note dated 9/23/21, identified R14 was evaluated by her PCP during routine rounds. The PCP was updated that R14 had some sleepiness in the a morning and continued with anxiety and propelling her wheelchair constantly causing her to become very fatigued and often decreased her intake. The PCP did not address R14's hospice referral progress. During interview on 9/29/21, at 11:56 a.m. the social work designee (SWD) stated the charge nurse usually started all hospice referrals. The charged nurse talked with the resident's family, then the the resident's doctor to obtain an order for referral and then sent the referral to Hospice. The SWD explained she was new to her role . A referral was ordered on 8/3/21, and was sent to the hospice agency; however, R14 was still on the hospice waiting list because the hospice agency did not have adequate staffing. The goal was for R14 to be assessed and admitted to hospice as soon as hospice agency had staffing to admit R14. The SWD was certain the charge nurse was still in frequent contact with hospice agency regarding the referral, but the SWD found no documentation supporting any communication between the facility and the hospice agency. No alternatives such as a palliative care plan were considered for R14 even though she was referred for hospice care approximately two months prior. During a phone interview on 9/29/21, at 12:08 p.m. registered nurse (RN)-A stated she was aware of R14's hospice referral and spoke with FM-A and doctor as R14 had yet to be assessed and admitted to hospice care. Neither had wanted	F 849	Information on the Essentia Comfort Care policy was shared in the family newsletter on 11/5/21 and will be provided to residents or their representatives at each care plan conference quarterly. G. Comfort Care protocol will be discontinued if the resident/ representative elects to enroll in a hospice program. H. The Social Service Designee or DON will offer to assist residents or their representatives to transfer to another facility to arrange for the provision of hospice services, if they desire. I. Residents status and necessity for Comfort Care/Hospice will be reviewed at monthly QAPI meetings with the Medical Director. J. Completion date 11/11/21	

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R14 referred to another hospice agency. There was no approximate date when hospice would be adequately staffed to accommodate R14's referral, but RN-A would send the referral to another hospice when either FM-A or doctor were tired of waiting. RN-A felt the facility staff were able to care for R14 and her family and doctor agreed with this. RN-A stated she had not documented any of her conversations with the family or the doctor.

During a phone interview on 9/29/21, at 12:17 p.m. FM-A stated her mom was referred to hospice and she really wished it had happened sooner, but was told the hospice agency did not have staff to see her mom. FM-A stated she was told the hospice agency could not admit R14 due to staffing and was not offered alternative options such as seeking another hospice agency or moving the resident to another facility that could accomidated another hospice agency services, or palliative care. "Whoever can get the job done at this point", but no one had talked about it since they said the hospice did not have staffing. I just wish it would get taken care of."

R14's medical record lacked any evidence of communication to the family on end of life care options.

During a phone interview on 9/30/21, at 9:16 a.m. the hospice clinical nurse manager stated they did receive a referral for R14 and the information was reviewed; however, they did not have staffing to accommodate the request. The facility was notified and explained R14 would be placed on a waiting list. There was no approximation when the hospice could accommodate the referral and staffing was a serious factor. The facility was

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instructed on their options: wait until staffing was available, refer to another agency, or the nurse manager could be a resource for them if they wanted to create a palliative care plan for R14. Ultimately, referrals were reviewed on a case by cases basis. Hospital discharges were always the highest priority over referrals from a long term care facility because the facility residents had caregivers that were capable of caring for the resident.

During a phone interview on 9/30/21, at 9:32 a.m. the hospice social worker stated she did reach out to FM-A and explained they did not have current staffing to assist R14. She did not discuss options other than waiting for staffing because she believed the facility would address these with the family.

During interview on 9/30/21, at 10:55 a.m. RN-A stated she talked with R14's family and they were given the option of other hospice agencies in the area; however, R14's family chose the facility's contracted agency. At first, it was going to be a two week wait for R14 to be admitted to hospice and R14's family agreed with that. RN-A checked on the referral approximately every week, but had not documented this. Additionally, no alternative care plans or options were considered because they were not needed because the facility cared for R14's needs. A palliative care plan was not considered because R14's PCP was the hospice director and would know what to do.

During interview on 9/30/21, at 11:01 a.m. the registered dietitian (RD) stated R14 had a significant weight loss. The facility offered supplements on and off without success. R14 was very active and wheeled throughout the

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facility constantly and this was a factor in her weight loss as well. The IDT met weekly to discuss R14 to consider options for her; however, a palliative care plan was not considered. Ultimately, the RD wanted R14 to eat what she wanted to eat wherever she wanted to eat as long as R14 could be safe.

During interview on 9/30/21, at 3:48 p.m. the facility administrator stated he was new to his role; however, believed there were hospice residents in the facility and was unaware of referrals not being fulfilled. His expectations were staff would discuss end of life options with family and attempt other hospice agencies if available or assist the family to accommodate other options such as a palliative care plan. He expected a solution be created within a two week timeframe.

R1's quarterly MDS dated 6/29/21, identified R1 had severe cognitive impairment. Diagnoses included dementia and chronic obstructive pulmonary disease (COPD). The MDS did not identify R1 was receiving hospice or palliative (end-of-life) care.

R1's care plan dated 7/15/21, did not include end of life care interventions or if R14 was receiving hospice or palliative care services.

R1's physician orders dated 8/19/21, identified a referral to hospice due to COPD, with a start date of 8/19/21, and a signed date of 9/22/21.

R1's Physician Nursing Home Notes identfiied the following

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- 8/5/21, R1 was losing weight related to COPD and had a life expectancy of less than 6 months.

- 9/1/21, R1 was not eating as well and was losing weight. The note also directed to have hospice see R1 as soon as possible.

R1's Monthly High Risk Nutrition Assessment dated 8/30/21, identified R1 had a significant weight loss of 15 pounds (11.3%) in the past 175 days and was referred to hospice a couple weeks prior. The RD's interventions were to continue to monitor R1's weight, vital signs, oral intake and provide weekly rounds.

During interview on 9/29/21, at 12:35 p.m. R1's family member (FM)-B stated the facility initially updated her regarding R1's hospice referral but was not updated further until 9/29/21.

During interview on 9/30/21, at 9:16 a.m. the hospice clinical nurse manager stated they had received a hospice referral for R1 but were unable to complete the assessment due to staffing issues. The facility was notified of the inability to complete the assessment and that an estimated time of assessment was unavailable.

- At 2:22 p.m. the social services designee (SSD) stated R1 was referred to hospice about two months ago, but hospice was unable to assess R1 due to staffing issues. SSD stated two months was too long to wait to be admitted into hospice.

- At 10:24 a.m. registered nurse (RN)-A stated R1 was referred to hospice on 8/19/21 but was unable to be admitted due to hospice staffing

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F 849	Continued From page 20 issues. The physician and family were made aware of the issues and family were provided other options but were okay with waiting. R1's medical record lacked any evidence of communication to the family on end of life care options. During interview on 9/30/21, at 3:48 p.m. the administrator stated he was unaware of R1's hospice referral and the lack of hospice services. It was his expectation that staff would discuss and assist the family with other options for hospice services or find another way to accommodate the resident's needs. Further, the administrator stated it was his expectation hospice referrals and alternatives to be initiated within a two-week time frame. The facility policy Home Health and Hospice Admission Resident in Contracted Skilled Nursing Facility/Nursing Home dated 4/25/19, indicated the facility would initiate Hospice services in a skilled nursing facility (SNF) resident that resident in a contracted facility. To evaluated the physical, psychosocial and spiritual needs for a resident/family entering the Hospice program. To insure and facilitate communication between the SNF/NH, Hospice staff, and families. Hospice in the SNF/NH is designed to optimize end-of-life services in the facility. Hospice services enhance care provided to the resident and the resident's family and area a resource for the facility staff in pain and symptom management, addressing complex psychosocial issues, and complying with regulatory and facility standards and requirements.	F 849		
F 880 SS=D	Infection Prevention & Control	F 880		11/11/21

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F 880	Continued From page 21 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 22 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was provided following personal cares for 1 of 2 residents (R14) observed during the provision of activities of daily living (ADLs) Findings include: R14's quarterly Minimum Data Set (MDS) dated 7/27/21, identified R14 required assistance with	F 880	F880 First Care Living Center has established and maintains an infection and prevention control program designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. Hand hygiene is an identified way to help reduce the spread of germs which could negatively impact	

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F 880	Continued From page 23 ADLs. Diagnoses included Parkinson's disease, dementia and chronic obstructive pulmonary disease (COPD). R14's care plan dated 8/20/21, directed staff to provide assistance with partial bathing twice daily and as needed. During observation on 9/29/21, at 6:57 a.m. nursing assistant (NA)-A entered R14's room to assist R14 with morning bathing, dressing and grooming cares. NA-A obtained supplies that included a basin of warm water, a washcloth and hand towel from R14's bathroom. NA-A placed the basin on R14's bedside stand along with the towel and washcloth. NA-A placed R14's clean incontinent brief to the end of R14's bed and obtained R14's clothing from her closet. NA-A placed R14's clothing at the end of R14's bed and then applied gloves; however, NA-A was not observed to perform hand hygiene. NA-A removed R14's blankets and assisted R14 to lie on her back. NA-A washed R14's face and underarms. NA-A rinsed the washcloth in the basin and washed then dried R14's perineal area. R14 was assisted to her left side and NA-A washed and dried R14 buttocks. NA-A placed R14's clean incontinent brief, without removing her gloves and performing hand hygiene and continued to wear her soiled gloves. When R14 was fully dressed with shoes on, NA-A assisted R14 to transfer from her bed to her wheelchair and assisted R14 into her bathroom. NA-A then removed her soiled gloves and applied new gloves, without performing hand hygiene prior to putting on the clean gloves. NA-A obtained R14's toothbrush, kidney basin and toothpaste. NA-A applied toothpaste and encouraged R14 to brush her teeth independently. When R14 finished oral care, NA-A removed her gloves and assisted R14	F 880	residents and staff. First Care Living Center/Essentia Health recognizes the importance of proper hand hygiene and is responsible to ensure that hand hygiene is completed appropriately. A. Facility policy for hand hygiene was reviewed by DON and IP on October 13, 2021. Hand Hygiene policy was compared with the CDC guidance and CMS requirements. B. NA-A was educated on proper hand hygiene practices on October 13 2021, and November 4, 2021. Education provided from EDUCARE Infection Control techniques includes the chain of infection, hand hygiene, standard precautions, transmission based precautions, use of protective equipment. Discussion with NA-A on the RCA to determine the cause of failure to wash hands per infection control guidelines and facility policy. Just Culture algorithm followed to review with NA-A the behavior which resulted in human error and the inadvertent lapse in judgement, and how to improve practices. Audits of Hand Hygiene by observation with NA-A completed on 10/13/21 and 11/4/21. Hand Hygiene procedure skill competency done 11/4/21 by observing the hand washing technique. C. All staff education on proper hand hygiene practices was provided to all staff at staff meetings on October 14, and 15, 2021 and at staff meetings November 3, and 4, 2021. Education provided from	

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F 880	Continued From page 24 to the dining room for breakfast. NA-A was not observed to perform hand hygiene until after R14 was positioned at the dining table. During interview on 9/29/21, at 8:16 a.m. NA-A stated hand hygiene should be performed after removing of gloves and she thought she washed her hands. During interview on 9/30/21, at 10:55 a.m. registered nurse (RN)-A stated hand hygiene was expected whenever a staff member came into contact with a resident or when they remove soiled gloves. Further, not washing their hands was unacceptable. Hand hygiene audits were conducted daily; however, RN-A was unsure if every situation was audited. For example, audits usually occurred when staff were going into a room or coming out of a room, but not during ADL observations. In-the-moment education would be provided to staff when hand hygiene was missed or forgotten. The facility policy Hand Hygiene dated 6/20/19, identified practices and expectations for healthcare workers, prevent the transmission of microbial pathogens and aid in the reduction of healthcare associated infections. The policy directed staff must perform hand hygiene before resident contact or contact with the resident's environment, after resident contact, before a clean procedure, after body fluid exposure risk, when moving from a contaminated body site to a clean body site during resident care, before putting on gloves, after removing gloves, before administering medication, after sneezing or coughing, before and after eating or after using the bathroom.	F 880	EDUCARE Infection Control techniques includes the chain of infection, hand hygiene, standard precautions, transmission based precautions, use of protective equipment. Education was provided to staff unable to attend to be completed prior to their next scheduled shift. All staff shown & reviewed Hand Hygiene Audit tool. Documentation by their signature that they have received and understood the information, on proper hand Hygiene, that will be audited. D. Hand hygiene education will be provided to all new employees during the onboarding process and prior to starting direct care job orientation. E. All staff will complete annual and PRN hand hygiene education which will include the Hand Hygiene procedure skill competency by observing their hand washing technique. F. DON, IP, or designee will conduct hand hygiene audits by observation on all shifts daily on each community (north and south) x1 week, then one AM and one PM audit on each (north and south) community weekly x 4 weeks and randomly thereafter. G. Compliance and audit results will be reported to QAPI. Facility will follow QAPI recommendations to discontinue audits when compliance appropriate. H. Completion date 11-11-21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	C 09/30/2021

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F 880	Continued From page 25 The Centers for Disease Control and Prevention (CDC) Clean Hands for Healthcare Providers dated 1/7/21, identified cleaning your hands reduced the spread of potentially deadly germs to residents and decreased the risk of healthcare provider infection caused by germs acquired from residents. Hand hygiene should be done immediately before touching a resident, before performing an aseptic (clean) task or handing an invasive device, before moving from work on a soiled body site to a clean body site on the same resident, after touching a resident or the immediate environment, after contact with bodily fluids and/or after glove removal.	F 880		

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	245512	A. BUILDING **01 - NURSING HOME** B. WING _____	**09/28/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	**900 HILLIGOSS BOULEVARD SOUTHEAST** **FOSSTON, MN 56542**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Essentia Health NH 01 Main Building 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/05/2021

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

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. Essentia Health NH is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(111) construction. In 1997, additions to the sleeping rooms and an activities room to the northeast corner were constructed. These additions are Type II(111) construction. The building is divided into 4 smoke zones with a 30 minute and two 2-hour fire barriers.	K 000		

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K 000	Continued From page 2 The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13, The Standard for the Installation of Automatic Sprinkler Systems. The facility has a fire alarm system with smoke detection in the corridor system, in all sleeping rooms, and in common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code." The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system. The facility has a capacity of 50 beds and had a census of 35 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm in accordance with NFPA 101 "Life Safety Code" 2012 edition, section	K 345	Maintenance Manager implemented a semiannual inspection to meet the NFPA 101 "Life Safety Code" 2012 edition, section 9.6.1.3, and NFPA 72 "National	10/29/21

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K 345	Continued From page 3 9.6.1.3, and NFPA 72 "National Fire Alarm and Signaling Code" 2010 edition, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/28/2021, at 11:30 AM, during a review of all available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. This deficient condition was verified by a Maintenance Supervisor.	K 345	Fire Alarm and Signaling Code" 2010 edition, sections 14.5.3. and 14.6.2.4. We currently have Simplex completing the annual inspection that was completed on 9/3/21, and maintenance manager has set up an automated reminder in preventative maintenance computer system to have the maintenance staff complete the second visual inspection of all the required devices 6 months from the date of current inspection. Maintenance manager has also set an ongoing reminder in his calendar to check the inspection is completed, documented. The Supervisor for the maintenance department will be responsible for making sure this requirement is completed on a semiannual basis.	