DEPARTMENT OF HEALTH						DICARE & MEDICAID SERVICES
	-	. –	-		AND TRANSMITTAL FE SURVEY AGENCY	ID: KMB9
 MEDICARE/MEDICAID PROVIDER (L1) 245569 STATE VENDOR OR MEDICAID NO 	R NO.	3. NAME AND AI (L3) HALSTAD I (L4) 133 FOURT	DDRESS OF FAC	CILITY FER	IE SURVEY AGENCY	Facility ID: 00764 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 075740300		(L5) HALSTAD,	MN		(L6) 56548	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9) 6. DATE OF SURVEY 11/21/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 44 (L37) 16. STATE SURVEY AGENCY REMARKANCE	19 SNF (L39)	Compliance 1. A B. Not in Comp Requirements ICF (L42)	unce With equirements e Based On: cceptable POC liance with Progr and/or Applied V IID (L43)	am Waivers:	And/Or Approved Waivers Of 7 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
17. surveyor signature Tammy Williams, HF	E NEII	Date : 0	09/16/2016	(L19)	18. STATE SURVEY AGENCY	APPROVAL Date: , Enforcement Specialist 01/03/2017 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	. ,	OFFICE OR SINGLE S	
 19. DETERMINATION OF ELIGIBILI <u>X</u> 1. Facility is Eligible to Pa <u>2</u>. Facility is not Eligible 	TY	20. COM	IPLIANCE WITH HTS ACT:		21. 1. Statement of Finan	ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 07/01/1991 (L24)	23. LTC AGREEN BEGINNINC (L41)		4. LTC AGREEN ENDING DA (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03 Bick of Involuntary Termination	05-Fail to Meet Health/Safety ment 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS a of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	07 <u>-Provider Status Change</u> 00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION 09/23/2016	I OF APPROVAL	. DATE		
	(L32)			(L33)	DETERMINATION APPE	ROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

On November 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 2, 2016 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 4, 2016 and a Federal Monitoring Survey (FMS) completed on August 26, 2016. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of September 20, 2016. Based on our PCR, we have determined that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 4, 2016 and the FMS completed on August 26, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of September 8, 2016. The CMS Region V Office concurred and authorized this Department to notify the facility of these actions:

Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 4, 2016, be rescinded.

In CMS letter of September 8, 2016 CMS advised the facility that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 4, 2016, due to denial of payment for new admissions. Since the facility attained substantial compliance on September 16, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b forms for the health, life safety code and FMS revisits.

Effective September 16, 2016, the facilty is certified for 44 skilled nursing facilty beds.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245569

January 3, 2017

Ms. Angela Nelson, Administrator Halstad Living Center 133 Fourth Avenue East Halstad, Minnesita 56548

Dear Ms. Nelson:

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 September 16, 2016 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 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 Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 5, 2016

Ms. Angela Nelson, Administrator Halstad Living Center 133 Fourth Avenue East Halstad, Minnesota 56548

RE: Project Number S5569027, S5569027

Dear Ms. Nelson:

On August 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 4, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On August 26, 2016, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On September 8, 2016, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 4, 2016 (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of September 8, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 4, 2016.

On November 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 2, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued

Halstad Living Center December 5, 2016 Page 2

pursuant to a standard survey, completed on August 4, 2016 and a Federal Monitoring Survey (FMS) completed on August 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 20, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 4, 2016 and the FMS completed on August 26, 2016, effective September 16, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of September 8, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 4, 2016, be rescinded. (42 CFR 488.417(b)).

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 4, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 4, 2016, is to be rescinded.

In CMS letter of September 8, 2016 CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 4, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 16, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245569 _{Y1}	B. Wing	Y2	11/21/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAD LIVING CENTER		133 FOURTH AVENUE EAST		
		HALSTAD, MN 56548		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	N	DATE	ITEM	DATI	E ITE	м	DATE
Y4		Y5	Y4	Y	5 Y4		Y5
ID Prefix	F0221	Correction	ID Prefix F0241	Correc	ction ID Pre	fix F0280	Correction
Reg. #	483.13(a)	Completed	Reg. #	Comp	leted Reg. #	483.20(d)(3), 483.1 (2)	0(k) Completed
LSC		09/08/2016		09/08/2	2016 LSC		09/08/2016
ID Prefix	F0282	Correction	ID Prefix F0312	e Corre	ction ID Pre	fix F0314	Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	Comp	leted Reg. #	483.25(c)	Completed
LSC		09/08/2016		09/08/2	2016 LSC		09/08/2016
ID Prefix	F0334	Correction	ID Prefix	Correc	ction ID Pre	fix	Correction
Reg. #	483.25(n)	Completed	Reg. #	Comp	leted Reg. #		Completed
LSC		09/08/2016			LSC		
ID Prefix		Correction	ID Prefix	Correc	ction ID Pre	fix	Correction
Reg. #		Completed	Reg. #	Comp	leted Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correc	ction ID Pre	fix	Correction
Reg. #		Completed	Reg. #	Comp	leted Reg. #		Completed
LSC			LSC		LSC		
REVIEWE		REVIEWED BY (INITIALS) GA/MM	date 12/05/2016	SIGNATURE OF SURVEYO	R 32603		date 11/21/2016
REVIEWE	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE
FOLLOWL 8/4/2016	JP TO SURVEY CO			ANY UNCORRECTED DEFIC TED DEFICIENCIES (CMS-25			

KMB912

POST-CERTIFICATION REVISIT REPORT

			DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245569 _{Y1}	B. Wing	Y2	9/2/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAD LIVING CENTER		133 FOURTH AVENUE EAST		
		HALSTAD, MN 56548		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	м	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix Reg. # LSC	NFPA 101 K0029	Correction Completed 08/09/2016	ID Prefix Reg. # LSCK0050	Correction Completed 08/09/2016	ID Prefix Reg. # LSC	NFPA 101 K0144	Correction Completed
ID Prefix Reg. # LSC	NFPA 101 K0147	Correction Completed 08/09/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) TL/MM REVIEWED BY (INITIALS)	date 12/05/2016 date	SIGNATURE OF SURVEYOR 365	536	0	ate 9/02/2016 ate
FOLLOWL 8/8/2016	JP TO SURVEY CO			ANY UNCORRECTED DEFICIENCIES ED DEFICIENCIES (CMS-2567) SEN			YES NO

KMB922



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered December 5, 2016

Ms. Angela Nelson, Administrator Halstad Living Center 133 Fourth Avenue East Halstad, Minnesota 56548

Re: Reinspection Results - Project Number S5569027

Dear Ms. Nelson:

On November 21, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 4, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /		MULTIPLE CONSTRUCTION		DATE OF REVISIT	Г
IDENTIFICATION NUMBER		A. Building			
00764	Y1	B. Wing	Y2	11/21/2016	Y3
NAME OF FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAD LIVING CENTER			133 FOURTH AVENUE EAST		
			HALSTAD, MN 56548		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	м	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	20510	Correction	ID Prefix	20520		Correction	ID Prefix	20530		Correction
Reg. #	MN Rule 4658.03 Subp. 2	00 Completed	Reg. #	MN Rule Subp. 3	e 4658.0300 B	Completed	Reg. #	MN Rule 4658.030 Subp. 4	0	Completed
LSC		09/08/2016	LSC			09/08/2016 	LSC			09/08/2016
ID Prefix	20560	Correction	ID Prefix	20565		Correction	ID Prefix	20900		Correction
Reg. #	MN Rule 4658.04 Subp. 2	05 Completed	Reg. #	MN Rul Subp. 3	e 4658.0405	Completed	Reg. #	MN Rule 4658.052 Subp. 3	5	Comp l eted
LSC		09/08/2016	LSC			09/08/2016	LSC			09/08/2016
ID Prefix	20920	Correction	ID Prefix	21805		Correction	ID Prefix			Correction
Reg. #	MN Rule 4658.05 Subp. 6 B	25 Completed	Reg. #	MN St. Subd. 5	Statute 144.651	Completed	Reg. #			Completed
LSC		09/08/2016	LSC			09/08/2016	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			_	LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) GA/MM	date 12/05/	2016	SIGNATURE OF S	URVEYOR	32603		date 11/21	1/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWI 8/4/2016	JP TO SURVEY CO	DMPLETED ON			ANY UNCORRECT ED DEFICIENCIES					6 🗌 NO

KMB912

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services Midwest Division of Survey and Certification Chicago Regional Office 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519



CMS Certification Number (CCN): 245569

September 8, 2016

Ms. Angela Nelson, Administrator Halstad Living Center 133 Fourth Avenue East Halstad, MN 56548

Dear Ms. Nelson:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY Cycle Start Date:

STATE SURVEY RESULTS

On August 4, 2016, a health survey and on August 8, 2016, a Life Safety Code (LSC) survey were completed at Halstad Living Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance with the most serious deficiencies at Scope and Severity (S/S) level D, cited as follows:

- F221 -- S/S: D -- 483.13(a) -- Right to be Free from Physical Restraints
- F241 -- S/S: D -- 483.15(a) -- Dignity and Respect of Individuality
- F280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right to Participate Planning Care-Revise CP
- F282 -- S/S: D -- 483.20(k)(3)(ii) -- Services by Qualified Persons/Per Care Plan
- F312 -- S/S: D -- 483.25(a)(3) -- ADL Care Provided for Dependent Residents
- F314 -- S/S: D -- 483.25(c) -- Treatment/Svcs to Prevent/Heal Pressure Sores
- F334 -- S/S: D -- 483.25(n) -- Influenza and Pneumococcal Immunizations

The MDH advised you of the deficiencies that led to this determination and provided you with a copy of the survey report (CMS-2567).

FEDERAL MONITORING SURVEY

On August 26, 2016, a survey team representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious cited as follows:

• F248 -- S/S: E -- 483.15(f)(1) -- Activities Meet Interests/Needs of Each Res

- F363 -- S/S: E -- 483.35(c) -- Menus Meet Res Needs/Prep in Advance/Followed
- F366 -- S/S: E-- 483.35(d)(4) Substitutes of Similar Nutritive Value

The findings from the FMS are enclosed with this letter on form CMS-2567. Also enclosed is a list of the "resident identifiers" used in writing the Statement of Deficiencies. The "resident identifiers" will enable you to identify any specific residents referred to in the CMS-2567.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the enclosed deficiencies cited at the FMS. 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.

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; and
- An electronic acknowledgement signature and date by an official facility representative.

INFORMAL DISPUTE RESOLUTION

The MDH offered you an opportunity for Informal Dispute Resolution (IDR) following its survey visits. A request for IDR does not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR §488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Stephen Pelinski at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care
- Remedies imposed
- Alleged failure of the surveyor to comply with a requirement of the survey process

- Alleged inconsistency of the surveyor in citing deficiencies among facilities
- Alleged inadequacy or inaccuracy of the IDR process

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your ePOC. You must provide an acceptable ePOC for <u>all</u> cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

Please note, in accordance with 42 CFR §488.431, the facility must request independent IDR in writing within 10 days of receipt of CMS's offer. However, a facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the civil money penalty.

SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings we are imposing the following remedy:

• Mandatory denial of payment for new admissions effective November 4, 2016

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488 Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective November 4, 2016, if your facility does not achieve compliance within the required three months. This action is mandated by the Act at §§ 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR § 488.417(b). We will notify Noridian Administrative Services that the denial of payment for all new Medicare admissions is effective on November 4, 2016. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective November 4, 2016.

You should notify all Medicare and 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 Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION

If your facility has not attained substantial compliance by February 4, 2017, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §1819(h) and §1919(h) and Federal regulations at 42 CFR §488.456 and §489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination

goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR §489.57 will apply.

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 (NATCEP) 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 \$5,000; 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 4, 2016, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Halstad Living Center will be prohibited from offering or conducting a NATCEP for two years from November 4, 2016. You will receive further information regarding this from the MDH. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the MDH and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed the following remedy:

• Mandatory denial of payment for new admissions effective November 4, 2016

If you disagree with the findings of noncompliance which resulted in this imposition, and the finding of SQC which resulted in the loss of NATCEP approval, 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 Federal regulations at 42 CFR § 498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at <u>https://dab.efile.hhs.gov/</u>. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at <u>https://dab.efile.hhs.gov/user_sessions/new</u> to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized

representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that <u>all</u> hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Nancy K. Rubenstein, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, D.C. 20201

A request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice. It is important that you send a copy of your request to our Chicago office to the attention of Tamika J. Brown.

CONTACT INFORMATION

If you have any questions please contact Tamika J. Brown, Principal Program Representative at (312) 353-1502. Information may also be faxed to (443) 380-6614.

Sincerely,

Tamika J. Brown Acting Branch Manager Long Term Care Certification & Enforcement Branch

cc: Minnesota Department of Health Minnesota Department of Human Services Office of Ombudsman for Older Minnesotans Stratis Health

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB	<u>3 NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION (X3	,	E SURVEY PLETED
		245569	B. WING			08/2	26/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 166 SS=D	RESOLVE GRIEVA A resident has the r facility to resolve gr have, including thos of other residents. This REQUIREMEN by: Based on observat and resident intervit 1 of 22 Stage 2 res Specifically, R33 ex regarding a lack of	ight to prompt efforts by the ievances the resident may se with respect to the behavior NT is not met as evidenced ion, record review, and staff ew, the facility failed to resolve idents (R33) grievance. pressed a complaint assistance from staff to walk	F 1	66	F0166 It is the policy of Halstad Living Center encourage residents and family to communicate verbally or in writing any concerns, problems, or recommend	er to y	9/16/16
	independent. Findings include: The "(Facility) Griev for Resident and Fa policy of the facility, family to communic concerns, problems relating to care or to resident bill of rights included discussing supervisor of the de department of nursi Director of Nursing being the contact p resolved, a grievant the resident. All grie in no more than 7 w R33 was admitted to Current diagnoses, Minimum Data Set	her goal of becoming more vance Policy and Procedure amilies" indicated it was the "to encourage residents and ate verbally or in writing any s, or recommend changes or report a violation of the s." Recommended steps the matter first with the epartment involved. For the ing, the Charge Nurse or (DON) were identified as ersons. If issues were not ce form could be completed by evances would be addressed vorking days. o the facility on 1/30/15. from the 4/4/16 quarterly (MDS) assessment, included ER/SUPPLIER REPRESENTATIVE'S SIGN	JATI IBE		changes relating to their care, or to relaviolation of the residents bill of rights Corrective action taken for R33 was to re-educate staff by DON, regarding following up on a residents concerns/wishes/grievance when they expressed either verbally or in writing. addition to R33's FMP(functional maintenance program), which include ambulation, an additional ambulation program was added to her Plan of Car by her primary RN (Resident Care Coordinator) for staff to offer to assist to ambulate at least 1 additional time of the AM shift, and at least 1 time on the PM shift everyday. All staff working that day and upon net working day, reeducated regarding Residents Rights and their right to hav prompt efforts to resolve their grievand by DON and SSD. All other remaining staff reeducated on or before 9-16-16 DON and/or SSD. Audits will be conducted by speaking to	s. o y are . In es t R33 on e t R33 on e ext ve nces 5 by to	(X6) DATE

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

09/16/2016

PRINTED: 01/09/2017

Electronically Signed

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	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL		(X3) DATE	0938-039
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COM	PLETED
		245569	B. WING _			08/2	26/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 33 FOURTH AVENUE EAST		
HALSTA	D LIVING CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 166	Review of the quart dated 6/27/16 and a demonstrated the r with a Brief Intervie score of 15 (score of cognitively intact per Instrument). The re- free of both mood a 6/27/16 and 1/11/16 required extensive walking in her room resident was codeo able to stabilize with from seated to star- facing opposite direc- toilet. The resident walker and wheelch R33 was interviewed stated, "I don't get to resident stated it was walk more in order improve her ability	re, and high blood pressure. terly Minimum Data Set (MDS) annual MDS dated 1/11/16 esident was cognitively intact w for Mental Status (BIMs) of 13-15 consistent with er the Resident Assessment esident was coded as being and behavior symptoms. The 5 MDS indicated the resident assistance of one person for n and in the corridor. The d as not steady and only being h staff assistance for: balance oding, walking, turning around ection, and moving off the was coded as using both a	F 16	66	R33 to make sure she is satisfied w walking program by SSD/Designee for 1 month, and then randomly ther to ensure continued compliance. The the potential to affect any/all resider who may express a concern/grievance/wish regarding anything about their plan of care. SSD/Designee will review Grievance Policy with all staff annually and will reviewed with all new employees up hire. SSD will emphasize grievance and procedure to the current resider the next Resident Council meeting, individually if they do not attend, and Resident Council meeting thereafter part of their regular meeting. Specia emphasis on the Grievance policy a procedure will be reviewed with new admissions per SSD and/or Designe Audit results will be brought to the G committee quarterly by Social Servic Designee for further review/suggest until 100% compliance is sustained months.	3x/wk reafter his has hts e be boon policy nts at and d each r as al und v ee. QA ce tions	
	being dependent or R33 reported she w times a week by the stated, "Not very of dining room and es would like to walk n resident stated, "I fe	n a wheel chair for mobility. vas walked between 3 to 5 e Restorative Aide. R33 ten do I get to walk to the pecially on the weekends. I nore with the CNAs." The eel I sit too much." The he had not used a wheelchair					
	for mobility prior to about a year and a "I was walking with wheelchair. They (f therapy due to my v	her admission to the facility half ago. The resident stated, a walker and was not in a acility) said come here for weakness and I got put in a t is what happened. I did					

If continuation sheet Page 2 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/:	26/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 166	therapy till I reached the goal." The reside working on it (imple walking program)." expressed her com more with staff in hen number of staff incl Charge Nurse, the Designee (SSD), but outcome of her com asked if she filed a "Concern/Grievance filling out a grievand verbally expressed staff at different tim resolved. Record review conff walk more. Accordit note, "(R33) also st meals and that staff to walk more." The Social Service by administration as charge of the grieva interviewed on 8/25 she was aware of the more. The SSD stat resident's care com "(The resident) brow Nursing has discus walk the resident to was quite a while as Restorative Directo CNAs should also to stated no formal wr She further stated as	age 2 d my goal. They said I reached lent stated, "They say they are ementing a more frequent The resident stated she plaint about wanting to walk er care plan meeting and to a uding the Restorative Aide, the DON and to the Social Service ut she did not know what the nplaint was. The resident was formal grievance using the e Report." The resident denied ce report; however, stated she her complaint to a number of es and it had not been "irmed the resident's desire to ng to a 7/7/16, "Plan of Care" ated that she wants to walk to f should know that she wants Director (SSD) was identified s being the staff member in ance procedure. The SSD was 5/16 at 11:43 a.m. and stated he resident's desire to walk ted this was discussed at the ference. The SSD stated, ught it up at care conference. sed it and said they would o meals and to the bathroom. It go." The SSD stated the r walked the resident but the be walking her. The SSD itten grievance had been filed. a grievance should be initiated complaint could not be worked	F	166			

Facility ID: 00764

If continuation sheet Page 3 of 39

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		ON	FORM APPRO\ <u>1B NO. 0938-0</u> 3
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION ((X3) DATE SURVEY COMPLETED
		245569	B. WING		08/26/2016
NAME OF I	PROVIDER OR SUPPLIER	•	;	STREET ADDRESS, CITY, STATE, ZIP CODE	
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 166	out within a few day	ys. The SSD stated she was	F 166	5	
F 248 SS=E			F 248	3	9/15/16
	of activities designed the comprehensive	ovide for an ongoing program ed to meet, in accordance with assessment, the interests and al, and psychosocial well-being			
	by: Based on observa interviews, the facil R13, and R31) of 5 activities in the Sta	NT is not met as evidenced tions, record review, and staff ity failed to ensure 3 (R28, residents reviewed for ge 2 sample of 28 resident ate program of activities to		F248 It is the policy of Halstad Living Cent provide an ongoing program of activ designed to meet the interests and physical, mental and psychosocial well-being of each resident. Activity Director reassessed residen R13, R28, and R31 to ascertain spe interests and needs on 9-15-16. Inp	ities ts cific
	diagnoses, accordi Information," of Par encephalopathy, de	tted to the facility on 6/17/14 with ding to the 8/25/16 "Diagnosis 'arkinson's Disease, depression, dementia with behavioral lar disorder, and anxiety.		from residents, family, nursing staff activities staff was included in reassessment. Specific leisure inter- were addressed in care plans for residents 13, 28, and 31. The activity calendar is developed a	and ests nd
	comprehensive ass staff that drives the an assessment refe documented R28 h exhibited signs and	num Data Set (MDS - a sessment completed by facility care planning process), with erence date (ARD) of 7/18/16, ad impaired cognition and I symptoms of depression. He ing and impaired speech.		one to one visits are assigned based residents' assessed strengths, leisu interests, needs and interventions. T findings of this assessment are refle in each resident's care plan. Activity Director will reassess and audit all residents' activity care plans by 12-1 Activity staff were reeducated by Act	d on re The ected 5-16.

Facility ID: 00764

If continuation sheet Page 4 of 39

STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245569	B. WING _		08/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE	
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 248	seated in his wheel front of the nurses' On 8/22/16 from 2:: observed seated in interaction with staf stimulation, such as On 8/23/16 from 9:: again from 2:00 p.m observed seated in interaction with staf stimulation. On 8/24/16 from 9:: observed seated in interaction with staf stimulation. He was intermittently. On 8/23/16 at 9:32 attempted with R28 interview questions "yes" or "no" occas he attended activitie respond. The 7/27/16 "Activite Participation Review attended 13 group and has participate seems to enjoy son spend time watchint [R28] has enjoyed I some videos on Yo visits. He spends tii area and will work y building/crafting ma activity room." The	 Ichair in the common area in station. 20 p.m. to 4:00 p.m., R28 was common area without any ff or residents or any type of s music. 00 a.m. to 11:00 a.m. and n. to 3:00 p.m., R28 was common area without any ff or residents or any type of 50 to 12:07 p.m., R28 was common area without any ff or residents or any type of s observed sleeping a.m., an interview was B. He was unable to answer though he did nod his head ionally. When asked whether es at the facility, he did not ties - Quarterly/Annual w" documented, "[R28] has activities over the past quarter d in 15 [one to one] visits. He ne music events and will og the birds in the aviary hand massage and watching uTube during [one-to-one] me observing in the center with some of the anipulatives available in the assessment documented the re met and the current 	F 24	 Activities Department, or and documentation requi- 9-12-16 and 9-15-16. All staff were in-serviced leisure interests and leis on/before 9-16-16. Activity Director will audi residents' and new admi- participation charting for weekly for 3 months. On be initiated if resident pa- below 3-5 activities per v independent resident act attached) Activity Director will mon compliance by completin of one to one visit record tools and task observatio compliance is achieved. will then follow up by cord bi-monthly and monthly activity and monthly continued compliance. F reported to the QA communitation of the the the the the the the the the the	irements on on residents' ure needs t current ssion' activity each resident e to one visits will rticipation drops veek with little/no tivities. (see itor for ng weekly audits ls, data collection on until 100% Activity Director npleting audits to assure Results will be nittee quarterly	

If continuation sheet Page 5 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
		245569	B. WING			08/:	26/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	The 5/13/16 activity [R28] had a "Potent to] anxiety, physical communicating due goals were, "Reside [one-to-one] visit 1 interaction and sen- review date" and "T satisfaction with typ activity involvement review date." The a resident to and from neededIntroduce similar interests and interactionInvite/e involvement in activ as: music events, m folding towels. [R28 job'Invite/encoural members to attend to support participa treatment plan [R28 participation as req residentMonitor a for impact of medic levelPraise particivisits 1 [to] 2 times newspaper, hand lo activity calendar, his resident that they m not required to stay resident's right to re assistance/escort to chooses not to part the resident prefers center area, and lis sensory stimulation	v "Care Plan" documented tial for social isolation [related I limitations, difficulty to trach placement." The ent will actively engage in [to] 2 times per week for social sory stimulation through The resident will express be of activities and level of t when asked through the upproaches included: "Assist in activities as the resident to residents with d encourage/facilitate encourage resident's vities of choice/interest such norning social time, outings, 8] 'likes to have a age the resident's family activities with resident in order tionModify daily schedule, 8] to accommodate activity uested by the ttendanceMonitor/document al problems on activity ipationProvide [one-to-one] weekly using iPad, reading otionProvide resident with an ghlight interestsRemind the hay leave at any time and is for entire activityRespect efuseThe resident needs o activitiesWhen the resident icipate in organized activities, is to watch TV, observe in the ten to music for social and	F2	248			

If continuation sheet Page 6 of 39

CENTEI STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245569	. ,	S		FORM / MB NO. (X3) DATE COMI	01/09/2017 APPROVED 0938-0391 E SURVEY PLETED 26/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	received one-to-one 8/22/16, 8/12/16, 8/ 7/21/16, 7/11/16, 7/ of these visits were Stimulation." The group activity p documented the res activities on 8/15/16 On 8/25/16 at 3:16 stated R28 received a week, and attende a month. She stated attend more group a groups he coughed She stated his barri activities were prim in bed or that he ha early so he did not h for more frequent o interaction with the 2. Review of R13's assessment referent documented R13 his severely impaired c decision making. R but were not limited moderately impaired and unclear speech Review of R13's "C "Potential for social depression manifes cares/hospice", revi the following "Interv	e visits on: (11/16, 8/1/16, 7/22/16, (8/16, 7/2/16, and 7/1/16. Most documented as "Sensory barticipation record sident attended group 5, 8/10/16, 8/7/16, and 8/2/16. p.m., the Activity Director (AD) d one-to-one visits 1 to 2 times ed group activities 4 to 5 times d she would like to see him activities, but sometimes in a lot and had to be removed. iers to attending group arily that he spent a lot of time id to be removed from groups disrupt the activity. The AD have the staffing levels to allow one-to-one or small group resident. Quarterly MDS with an nce date (ARD) of 8/1/16, ad a memory problem and cognitive skills for daily 13's active diagnoses included d to dementia. R13 also had d vision, adequate hearing, n. are Plan" with a "Focus" of isolation r/t dementia and	F2	248			

Facility ID: 00764

If continuation sheet Page 7 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245569	B. WING			08/;	26/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	ongoing family invo family to attend spe Provide with activiti any changes to the dignity and end visi discomfort or distre resident's activation family/representativ bedside/in-room vis attend out of room activities which do n cognitive tasks. Eng activities such as have reading poetry or sl On 8/24/16 from 10 observed seated in common area. The be turned on, but th watching the televis continuous observat have repetitive verb answer surveyor qu On 08/25/2016 at 1 seated in her whee the television turner observed seated in area by the nurses' diversional activities Review of R13's "O dated 8/11/16, docu respond more posit other interaction. S	 Invite the resident's ecial events, activities, meals. Invite the resident's ecial events, activities, meals. Invite the resident of calendar of activities. Respect to a calendar of activities and symptoms of eases are displayed. Review in needs with the version to the resident needs 1:1 sits and activities if unable to events. The resident prefers not involve overly demanding gage in simple, structured and massage/lotion, music, hort stories." D:46am to 11:11am, R13 was the television room by the events the time of the ation. R13 was observed to be ation. R13 was observed to be behavior and was unable to usestions. D:31am, R13 was observed lohair the television room with d on. R13's eyes were 	F 2	248			

If continuation sheet Page 8 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/:	26/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	Continued From pa music, and did not a agitation or anxiety. interactions. She wi times her constant [R13] has accepted eye contact, at time " Review of R13's "Q dated 5/19/16, docu seems unable to to activities. When sea agitation increases self-talk and body n present for 9 activiti has not been able t continue to provide for social and sense Review of R13's do [untitled document] August 2016, provid 8/22/16, indicated F activities on the foll 2/24/16, 2/29/16, 3/ 5/2/16, 5/17/16, 6/6 7/18/16, 7/26/16, 7/ Review of R13's do [untitled document] August 2016, provid 8/22/16, indicated F activities on the foll 2/23/16, 5/17/16, 6/6 7/18/16, 7/26/16, 7/	age 8 appear to have increased [R13] seems to enjoy 1:1 ill hold a person's hand and at movements will stop or slow. I hand massage and will give es, when someone sings to her active participating in group ated near a group her level of as evidenced by increased novementsShe has been is over the last quarter but to participate in themWill 1:1 visits 1-2 times per week ory integration" cumented group activities for February 2016 through ded by the Activity Director on R13 participated in group owing days: 2/3/16, 2/17/16, /28/16, 4/18/16, 4/25/16, s/16, 6/20/16, 6/21/16, 6/22/16, /29/16, and 8/1/16.	n	248	DEFICIENCY)		
	7/21/16, 7/26/16, ar						

If continuation sheet Page 9 of 39

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/09/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245569	B. WING _			08/	26/2016	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-		
HALSTA	D LIVING CENTER				3 FOURTH AVENUE EAST ALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 248	being conducted in observed to attend During an interview Activity Director sta activities and was to week. The Activity I benefit from low stin as read and reminis further confirmed th 1:1 visits as schedu receive them more 3. Review of the Qu 8/15/16 revealed a Status (BIMS) score had a moderately in review of the Quarter revealed that R31 w staff member for low	group and individual activities the facility. R13 was not any of the activities. on 8/25/16 at 11:01am the ted that R13 enjoyed 1:1 o receive 1:1 visits 1-2 times a Director also indicated R13 mulation group activities, such see. The Activity Director nat R13 had not been receiving iled and would like for R13 to often. warterly MDS with ARD of Brief Interview for Mental e of 10, which indicates R31 npaired cognition. Further erly MDS dated 8/15/16 vas totally dependent on one comotion on and off the unit.	F 24	18				
	12/7/15 revealed in R31 stated that the reading materials w In an interview on 8 stated when asked that there were no a Observation of R31 12:30pm revealed r or music playing. Observation on 8/23	/23/16 at 12:30pm, R31 if he participated in activities activities. 's room on 8/23/16 at no reading materials present 5/16 at 11:37am revealed that s bed. There was no music						

If continuation sheet Page 10 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245569	B. WING			08/2	26/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 248	Observations on 8/2 numerous activities was not present for Observation on 8/2 lying in his bed, in h reading materials p Review of Care Pla following problem w and a revision date little or no activity in thought process du (CVA) and diagnosi of the care plan was satisfaction with the activity involvement review date. Revier care plan revealed one] 1:1 visits 1-2 ti attendance in activi Review of the unda Sheet" revealed tha activities on Tuesda Review of the docu June, July and Augu attended group acti seven times in July the most recent gro 8/21/16. Review of the docu June, July and Augu had been provided	23/, 8/24 and 8/2516 revealed being conducted, but R31 any of them. 5/16 at 2:30pm revealed R31 his room with no books or resent and no music playing. In for R31 revealed the with an initiated date of 5/13/16 of 8/22/16. The resident has hvolvement related to altered e to cardio vascular accident is of schizophrenia. The goal s for the resident to express e type of activities and level of t when asked through the wing the interventions for this the following: Provide [one to imes weekly and monitor ties. ted "1-1 Visit Check Off at R31 was scheduled for 1:1	F 2	248			

Facility ID: 00764

If continuation sheet Page 11 of 39

		AND HUMAN SERVICES			FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245569	B. WING _		08/	26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 248 F 280 SS=D	In an interview on 8 stated that R31 was 1-3 times weekly an Activity Director star received 1:1 activiti resident refused thi documented. In an interview on 8 of Nursing (DON) s that 1:1 activities be planned and if the that there would be reason they were n 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated unde participate in plannic changes in care an A comprehensive as interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi- legal representative	 3/24/16 the Activity Director is to receive 1:1 activity visits and had not. In addition, the sted that R31 should have es 1-2 times a week and if the is should have been 3/25/16 at 11:30pm the Director stated that she would expect e provided for R31 as care 1:1 activities were not offered documentation as to the ot. 0(k)(2) RIGHT TO INNING CARE-REVISE CP are right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or 	F 24	248		8/26/16

If continuation sheet Page 12 of 39

		AND HUMAN SERVICES			FORM	01/09/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245569	B. WING _		08/3	26/2016	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 280	Continued From pa	ge 12	F 28	30			
	by: Based on record re- interviews, the facili plans for two of (R1 Stage 2 sample we their care and servi plan was not update a fall intervention an number of actual fa not updated to refle staff. Findings include: 1. R19 was admitte with diagnoses, acc Diagnosis" list, of A behavioral disturbai glaucoma, transiem fracture of the right The significant chan a comprehensive a facility staff that driv process), with an A (ARD) of 8/2/16, do impaired cognition a symptoms not direct required extensive daily living and loco assistance with bala wheelchair for locor one fall with major i assessment. The 8/1/16 "Morse	NT is not met as evidenced eview, observations, and staff ity failed to ensure the care 9 and R33) 28 residents in the re revised to accurately reflect ces. Specifically, R19's care ed with the use of a low bed as nd to reflect an accurate Ills and R33's care plan was bet her desire to walk with the d to the facility on 12/29/10 cording to the 8/24/16 "Medical lzheimer's disease with nce, cataracts, arthropathy, t cerebral ischemic attack, and humerus. nge Minimum Data Set (MDS - ssessment completed by ves the care planning ssessment Reference Date foumented R19 had severely and exhibited behavioral cted toward others. She assistance with all activities of motion. R19 required ance and transfers and used a motion. R19 had experienced njury since the previous		F280 It is the policy of Halstad Living C complete a comprehensive care within 7 days after completion of comprehensive assessment; pre- the Interdisciplinary Team that ind the attending physician, a Registe Nurse, and other appropriate stat disciplines as determined by each residents needs, & if practicable, participation of the residents, fam legal representative, and periodid reviewed and revised by a team of qualified persons after each asse Corrective action taken for R19 w immediately update their plan of primary RN Resident Care Coord with the interventions that were a use (but not added to care plan), were 'bed in low position and mat beside bed' and the interventions wishes/concern that was express regarding walking. An extra walki program was added to R33's plat per primary RN Resident Care Coordinator. This has the potenti affect any or all residents that res The primary RN Resident Care Coordinators are responsible for continued updates/revisions of eac individual residents care plan. Review of the facilities policy and procedures regarding updating th care and specifically following the care for each individual resident of the reviewed with Licensed nursing b	olan the bared by cludes ered f in the ily or ally of ssment. vas to care (per inator) Iready in which con floor of R33's ed ng n of care al to ide here. ach e plan of were		

Facility ID: 00764

If continuation sheet Page 13 of 39

		AND HUMAN SERVICES			<u>OMB NO.</u>	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY PLETED
		245569	B. WING		08/2	26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST		
HALSTA	D LIVING CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 280	fallen before, havin the chart, impaired forgetting her limits An 8/3/16, 5:35 a.m "Aides were doing r sitting on the floor b resting against her position. She was e new injuries noted. except for her right (sic) from previous were done and all v monitor with [neuro hours for 24 hours.] The 8/3/16, 5:35 a.I documented R19 e fall out of her bed. S floor by her bed. Th One recommendati "Continue with hi/lo in the bed." On 8/24/16 at 2:30 a.m., R19 was obse room. The fall risk "Care F revised on 8/23/16, at risk for falls [rela needs, Confusion, I communication/com Morse fall risk asse is at a high [fall risk 7/21/16. No other fa documented goal w from additional falls	g more than one diagnosis on gait, and overestimating or . "Incident Note" documented, round (sic) and found resident beside her bed with her back bed. Bed was in the low easily assisted back to bed. No She moved all extremities arm which she has a fractured fall. [Neurological] checks was normal. Will continue to logical] assessments every 4 " m. "Incident/Accident Report" xperienced an unwitnessed She was found sitting on the ne bed was in the low position. for the team review was, w bed in lowest position while p.m. and on 8/25/16 at 8:40 erved lying in a low bed in her Plan," initiated on 7/12/16 and documented "The resident is ted to] Unaware (sic) of safety	F 28	0 DON/Designee will audit 3 reside plans per week x1mo., then 5 res monthly x1mo or until 100% com achieved and sustained. Licensed nursing staff were re-en- before survey team exited, by DC regarding the importance of upda plan of care immediately when interventions are put in place, pe- individual residents needs. Corrected 8-26-16. DON reviewed all current resider plans, along with the residents pi RN, to ensure that all care plans current and up to date with any interventions being used. Any ne patterns will be presented to the committee for further review/recommendations for 6 m	sidents pliance is ducated, DN, ating the r ts care imary were egative QA	

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING _			08/:	26/2016
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	-	
HALSTA	D LIVING CENTER				FOURTH AVENUE EAST STAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	and meet The (sic) The (sic) resident's encourage the reside all requests for ass protocol[Physical as ordered or [as m fracture to [right] pr 7/21/16. Splint to [ri Ortho. Resident usi locomotion on and [wheelchair] mobilit R19's care plan did fall intervention, not experienced a fall of On 8/25/16 at 10:4 ⁻ 2 stated the care pl falls and should hav bed, and she would immediately. Review of the facilit Intervention" policy and reviewed Septe "The RN will impler The interventions w on the Plan of Care 2. R33 was admitte Current diagnoses, Minimum Data Set anemia, heart failur Review of the quart dated 6/27/16 and a demonstrated the r with a Brief Intervie	resident's needsBe sure call light is within reach and dent to use it for assistance as ent needs prompt response to istanceFollow facility fall Therapy] evaluate and treat eeded]Recent fall with roximal humerus after fall on ight] arm with follow up with ing [wheelchair] at this time for off unit. Assist with 1 staff for sy." I not document a low bed as a r did it reflect she had on 8/3/16. 1 a.m., Registered Nurse (RN) lan should be updated after ve reflected the use of the low d update the care plan ty's "Falls: Assessment and , written in November 2004 ember 2015, documented, nent appropriate interventions. vill be documented and placed	F 28	30			

If continuation sheet Page 15 of 39

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245569	B. WING			08/26/2016	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER			-	33 FOURTH AVENUE EAST ALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Instrument). The refree of both mood a 6/27/16 and 1/11/16 required extensive a walking in her room resident was coded able to stabilize with from seated to stan facing opposite direction to the resident walker and wheelch R33 was interviewed stated, "I don't get the resident stated it was walk more in order improve her ability the was to be able to we being dependent or R33 reported she with the stated, "Not very of dining room and es would like to walk more in a stated, "I don't get the stated, "Not very of dining room and es would like to walk more in the stated, "Not very of dining room and es would like to walk more in the stated, "Not very of dining room and es would like to walk more in the stated, "The state a wheelchair fadmission to the fact ago. The resident stated to walker and was not said come here for and I got put in a with appened. I did the They said I reached stated, "They say the (implementing a more program)." The resident and the the stated to th	The Resident Assessment sident was coded as being and behavior symptoms. The MDS indicated the resident assistance of one person for and in the corridor. The as not steady and only being n staff assistance for: balance ding, walking, turning around action, and moving off the was coded as using both a	F 2	80			

Facility ID: 00764

If continuation sheet Page 16 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245569	B. WING _			08/;	26/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	staff in her care pla staff including the F Nurse, the Director Social Service Desi know what the outc Record review conf walk more. Accordi note, "(R33) also st meals and that staf to walk more." Review of the "Fund (FMP)" goal, dated would be walked or occurring Monday t Sheet" records for resident walked wit total of 17 times, m times a week. The August 2016 (throu resident walking wit total of 15 times, m times a week. Interview with Reha 10:15 a.m. revealed Functional Mainten a week. The Rehab (R33) is interested she wants to walk r in the FMP). We vis about that. She has losing ground is a g for her. She is not s one. CNAs could w girls (CNAs) to walk	In meeting and to a number of Restorative Aide, the Charge of Nursing (DON) and to the ignee (SSD), but she did not come of her complaint. Firmed the resident's desire to ing to a 7/7/16, "Plan of Care" ated that she wants to walk to if should know that she wants ctional Maintenance Program 3/24/15, indicated the resident nce a day, 3-5 days per week, hrough Friday. The "FMP Flow July 2016 documented the h the Rehabilitation Aide a eeting the FMP plan of 3-5 "FMP Flow Sheet" records for gh 8/24/16) documented the th the Rehabilitation Aide a eeting the FMP plan of 3-5 abilitation Aide on 8/24/15 at d the resident was on a ance Program (FMP) 3-5 days politation Aide stated, "She and has expressed to me that more (than what was provided sited a couple weeks ago a maintained her level. Not good thing. Walking is difficult steady and needs assist of ralk her. I tell (R33) to ask the	F 2	80			

If continuation sheet Page 17 of 39

DEPART CENTER	PRINTED: 01/09/2017 FORM APPROVED DMB NO. 0938-0391						
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245569			B. WING			08/26/2016	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST ALSTAD, MN 56548		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	residents and that s to routinely walk the addition to the walk week. However, shy walking the residen Rehabilitation Aide walk to dine progra On 8/25/16 at 1:23 interviewed and sta discussed with her opportunities to wal was discussed at th on 7/7/16. The Cha direct caregivers at verbal, face-to-face opportunities were Charge Nurse state everyday if she war no one shows up to CNA3 and CNA4, w resident, were inter a.m. Both CNAs rep walk independently to walk. The CNAs walker in her bedro use of a gait belt, to reported the only ac did, was done with reported the residen whether they walke reported they did no The resident was n from meals with CN accordance with he	she did not have enough time e resident to and from meals in ting provided 3-5 times a e stated the CNAs could be it to and from meals. The stated there was no formal m in place. p.m., the Charge Nurse was ted the resident had the desire to have more lk. The Charge Nurse stated it ne resident's care conference trige Nurse stated she told the bout the resident's wish (only e communication), but walking not scheduled or planned. The ed, "She (resident) can walk ths. I encouraged her to ask if o her room." who were care givers for the viewed on 8/25/16 at 10:46 ported the resident did not and required staff assistance reported the resident used her om, with their assistance and o go to the toilet. The CNAs dditional walking the resident the restorative staff. They ative staff was responsible for it to meals. When asked of the resident to meals, they	F 2	80			

If continuation sheet Page 18 of 39

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245569	B. WING			08/26/2016	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 280	meals and to move independently, usin survey. On 8/22/16, betwee resident was observed ining room for the and wheel herself be evening meal. On 8/24/16 at 9:35 herself from the din following the breakf On 8/25/16 at 11:59 observed to wheel here eating the noon me The following proble resident's care plan r/t (related to) osteo Fluctuations may ob extensive assistance symptoms on a give "Will continue to an staff, through next r interventions includ for ambulation with (front wheeled walk program 3-5 times a uses wheelchair as Although the reside walk more than 3-5 meeting in July 201 walk using the front	ved to travel back and forth to within her room g a wheelchair throughout the en 5:20 p.m. and 6:00 p.m., the ved to wheel herself to the evening meal, eat her meal, back to her room following the a.m., the resident wheeled ing room back to her room fast meal. 9 a.m. the resident was herself back to her room after al. 9 a.m. the resident was herself back to her room after al. 9 a.m. the resident was herself back to her room after al. 9 a.m. the resident was herself back to her room after al. 9 a.m. the resident was herself back to her room after al. 9 a.m. the resident was herself back to her room after al. 9 a.m. the resident was herself back to her room after al. 9 a.m. the resident was herself back to her room after al. 9 a.m. the resident was herself back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room after al. 9 a.m. the resident was her solf back to her room afte	F 2	280			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From paresident was observed independently, using survey. On 8/22/16, betweet resident was observed dining room for the and wheel herself be evening meal. On 8/24/16 at 9:35 herself from the dim following the breakf On 8/25/16 at 11:59 observed to wheel H eating the noon me The following proble resident's care plant r/t (related to) osted Fluctuations may observed symptoms on a give "Will continue to any staff, through next r interventions includ for ambulation with (front wheeled walk program 3-5 times a uses wheelchair as Although the reside walk more than 3-5 meeting in July 201 walk using the front to walk to meals with	 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 18 ved to travel back and forth to within her room g a wheelchair throughout the en 5:20 p.m. and 6:00 p.m., the ved to wheel herself to the evening meal, eat her meal, back to her room following the a.m., the resident wheeled ing room back to her room fast meal. a.m. the resident was herself back to her room after al. a.m. the resident was herself back to her room after al. a.m. the resident was herself back to her room after al. a.m. the resident was herself back to her room after al. a.m. the resident was herself back to her room after al. back to her room after cur between limited and ce, depending on arthritis en day." The care plan goal, hbulate with assistance from review." Care plan ed: extensive assist of 1 staff use of gait belt and FWW er); functional maintenance a week with rehab aide, and the main source of mobility. 	PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPL

If continuation sheet Page 19 of 39

PRINTED: 01/09/2017

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
245569			B. WING _		08/26/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST			
HALSTAD LIVING CENTER							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 280	Continued From page 19 resident's goal of wanting to improve in ambulation, walking to and from meals or specifically walking with the CNAs on a routine basis.		F 28	0			
F 325 SS=D		N NUTRITION STATUS DABLE	F 32	5		9/20/16	
	resident - (1) Maintains accept status, such as boot unless the resident demonstrates that t	cility must ensure that a ptable parameters of nutritional ly weight and protein levels, 's clinical condition this is not possible; and apeutic diet when there is a					
	by: Based on observat interview, the facility Stage 2 sampled re- with nutritional inter of unplanned weigh implement the phys Intervention Progra resident a sufficient survey.	NT is not met as evidenced tion, record review, and staff y failed to ensure 1 of 28 esidents (R9) was provided ventions to address a history it loss. The facility failed to sician prescribed Nutrition m (NIP) and serve the t and balanced diet during the		F325 Policy and Procedure addressin residents at nutritional risk were and updated to assure they are sufficient and balanced diet. For stressed as the first option as in before supplements are offered policy will include the specifics of nutritional supplement as a mea replacement with the guideline of	reviewed served a od will be tervention This f using l f being		
	According to a 7/6/	the facility on 3/11/11. 16, "Physician Progress Note", nt diagnoses included:		given when < 50% of meal is ea with the procedure of % of supp taken being documented by LPN in the MAR. All Nursing staff we on when to offer nutritional supp as a meal replacement and how	ten and ement J's/TMA's re trained lements		

Facility ID: 00764

If continuation sheet Page 20 of 39

		& MEDICAID SERVICES				MB NO.	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WING _			08/26/2016		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAD LIVING CENTER				13 H			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 325	Continued From pa	ge 20	F 3:	25			
	Continued From page 20 gastro-esophageal reflux disease. The significant change Minimum Data Set (MDS) assessment, dated 7/25/16, indicated the resident had a BIMs (Brief Interview for Mental Status) score of 9, consistent with moderate cognitive impairment. The resident was documented with a height of 65" (5'5" tall) and a weight of 124 pounds. The resident was coded as eating independently with set up assistance only. The resident was coded with highly impaired vision. The resident was prescribed a nutritional supplement 4 ounces, twice daily at 8:00 a.m. and at 6:00 p.m. that was initiated on 10/31/12 (review of August 2016 Physician's Orders). The resident had a diet order for regular diet. The resident's weight records demonstrated a recent 5.4% significant unplanned weight loss occurring in one month between 7/7/16 and 8/4/16. R9's weights, documented in the electronic medical record, showed a downward trend. Weights included: -136 pounds (lbs.) on 1/28/16 -128 lbs. on 4/28/16 -129 lbs. on 7/7/16 -122 lbs. on 8/4/16 -124 lbs. on 8/18/16			20	record percentage taken by reside Dietary staff were in-serviced on the above policy and procedure on Tu September 20th, 2016. Emphasis placed on the need for all staff to f with any resident that is not eating meal they have received to offer alternatives, encourage intake, an assistance if needed. NIP (Nutritional Intervention Program)Policy and Procedure rea and updated. NIP program include not limited to: adding 1/2 & 1/2; ex butter and/or gravy; brown sugar; cream; extra desserts; whole milk resident with unplanned weight los NIP tracking tool implemented 8/2 order to track which interventions NIP diet are provided to each resid These interventions will be monito the Dietary Mgr and adjusted whe effective with the consultant Dietitia involved in the process. (attachme Dietary staff were in-serviced on the diet and use of tracking tool on Tu Sept 20 by the Consultant Dietitia R9 has been re-assessed to assu nutritional interventions in place, in NIP diet features, are meeting res preferences and nutritional needs assure acceptable parameters of nutritional status are maintained. A residents at nutritional risk that are	ne esday, was ollow up the d offer //ewed es, but is tra ice for any s. 9/16 in from the dent. red by n not an nt) ne NIP esday n. re that ncluding ident's to	
	7/6/16, indicated the Levaquin (antibiotic infection and the re	cian Progress Note" dated e resident was treated with) for an upper respiratory sident being at risk for vere to encourage fluid intake.			receiving the NIP diet have been re-assessed to assure that nutritio interventions, including the NIP die features, are meeting each reside preferences and nutritional needs assure that acceptable parameter	et nt's to	

Facility ID: 00764

If continuation sheet Page 21 of 39
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DAT	0938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	COM	PLETED
		245569	B. WING		08/2	26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 325		-	F 325			
	On 7/11/16, the Dietitian wrote a "Nutrition/Dietary" note which indicated the resident's refusals of meals with a weight of 129 pounds. A recommendation was made for trial meals to be offered to the resident in her room. Meal intake records for the previous 3-month period were requested during the survey. Daily meal intake records were not maintained; however, a "7-Day Assessment Food/Fluid Intake Record" was to be completed for all residents prior to the MDS assessment due dates and was used in lieu of daily meal intake records. The "7-Day Assessment Food/Fluid Intake Record" for R9, from 7/19/16 through 7/25/16, was reviewed. The form documented zero intake for a total of 9 (out of a total of 14) breakfasts and dinners (noon meal). The resident's intake at supper (evening meal) varied between 25-100%.			nutritional status are maintained Dietary staff have been alerted t need to offer vegetables to resic select the basket meal option. T also covered during the Dietary on Tuesday Sept 20 by the Cons Dietitian. CDM/Consultant Dietitian/Desig visually audit 3x/wk for 4 weeks, weekly x 4 weeks, then random thereafter to maintain/sustain co All audits will be brought to QA b and/or Consultant Dietitian for re further recommendations for 6m	o the lents who his was in-service sultant nee will then y mpliance. by CDM eview and	
	supplement 4 ounce Physician prescribe	ngstanding order for nutritional tes twice daily, on 7/26/16, the ed 4 ounces of nutritional used as a meal replacement refused her meals.				
	resident's ideal boo pounds with the res mass index of 20.7 according to "Pock Assessment", 2013 Dietetics, L. Eckster resident's weight w pounds. The resider	note which indicated the dy weight range was 108-132 sident having a healthy body 5 (18.5 - 24.9 normal range et Resource for Nutrition 8, Academy of Nutrition and bin, K. Adams, pg. 30). The as documented as 124 ent received a regular diet with ment twice daily and as a meal				

If continuation sheet Page 22 of 39

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 01/09/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245569	B. WING		08/	26/2016
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	BUN. The resident and had a recent cl (heartburn medicati medication). The D on 7/26/16 was for A 7/28/16 "Plan of O resident was legally following orientation food. Set up was pr resident had a rece although symptoms returned to her prio The July 2016 "Car problem of "Reside intake r/t (related to basis e/b (evidence declines in weight." documented, "Goal (pounds)." Interven diet for extra calorie of food/fluids. Trial resident's intake im (ounces) nutritional Nutritional supplem Vitamin supplemen order. Water pitche The "Nutritional Inter policy and procedur residents with actua weight loss would re interventions to enco policy read, "Real fo priority, with comme to follow." The NIP options to increase	received vitamin supplements hange from Prilosec ion) to Pepcid (heartburn vietitian's new recommendation implementation of the NIP. Care" note indicated the y blind but able to feed self n to type and placement of rovided as needed. The ent respiratory infection, and s had improved, she had not or level of functioning. re Plan" documented the ent with inadequate calorie b) refusing meals on frequent ed by) slight, but steady ' The care plan goal I weight of 120-135# titons were: "Regular diet. NIP es at meals. Encourage intake meals in room to see if aproves. Lipped plate. 4 oz I supplement bid (twice a day). nent as meal replacement. ths per MD (Medical Doctor) er at bedside."	F 32			

Facility ID: 00764

If continuation sheet Page 23 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING	i		08/26/2016	
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	appropriate extra g made with ice creat and increased porti favorites of the resi Observations durin- to implement interv failure to serve the balanced diet: -Evening Meal on 8 Meal observations p.m. through 5:50 p fast food type bask contained a corn do served the dessert was pistachio pudd vegetable; creamy designated vegetable served to residents baskets. The reside interventions from t example: whole mil portions.) -Breakfast on 8/24/ At 8:15 a.m., the re dining room sitting resident had both w and was drinking co served any other be available and on the served one piece o cheese on top and was not served any 1/2 of the piece of to coffee only. She ate	r in hot cereal, where ravy, extra butter, smoothies m, pudding, Jello, magic cup, ons, especially of specific food dent. g the survey revealed a failure entions from the NIP and a resident an adequate, //22/16 were conducted from 5:01 o.m. R9 was served an oval et with a paper lining, which og and fries. The resident was according to the menu, which ing. R9 was not served a cucumbers were the ole and a tomato slice were that did not receive meal ent was not served any of the he NIP at this meal (for k, gravy, butter, or increased	F	325			

Facility ID: 00764

If continuation sheet Page 24 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245569	B. WING	i		08/	26/2016	
NAME OF I	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 325	dining room at 8:35 no cueing or encou meal. The resident to eat. The resident meal; the menu cal toast, and cold cerea and cold cereal) mi resident was not set from the NIP (for ex- half, syrup or brown butter, or increased -Dinner on 8/24/16 The resident was si waiting for her mea had coffee and wat served any other be available). The resi at 11:42 a.m., which bun and waffle fries the dessert per the served a vegetable and available on the resident ate a few o p.m. the resident we table. A staff memb table and asked he The resident remain minutes and then le the waffle fries and drank 50% of her c served any of the ir example: whole mil portions.) -Dinner on 8/25/16 At 11:33 a.m. the re- the dining room. The	a.m. The resident received ragement to eat during the was not offered anything else t was not served an adequate led for oatmeal, egg of choice, eal (menu called for oatmeal lk/juice/coffee/tea. The erved any of the interventions cample: whole milk, half and n sugar on hot cereal, extra	F	325	5			

Facility ID: 00764

If continuation sheet Page 25 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	steak with gravy, gr potatoes with gravy whipped topping for served coffee and v juice were available of the Jello and 759 green beans. The r the mashed potatoe drank all her coffee 12:05 p.m. the resid from the table. A nu noted how much th she wanted a push resident was not cu On 8/22/16 at 3:10 E1) was interviewed employed in the fac and she cooked on dinner meals. E1 st for the regular entre basket consisted of a hot dog, hamburg French fries. E1 sta they wanted the reg the end of the previ so dietary staff kne On 8/24/16 at 7:20 second time prior to asked about the NI on 7 tray cards that stated, "It has to do sure." Later when ti arrived at 7:45 a.m. that NIP stood for e such as butter half	reen beans and mashed . She was served Jello with r dessert. The resident was water for beverages (milk and b). The resident ate a few bites % of the meat with gravy and esident did not eat the any of es with gravy. The resident and half of her water. At dent wheeled herself away urse approached the table and e resident ate and asked her if in her wheelchair. The led to eat more. p.m., the Cook (Employee 1/ d. She stated she had been sility for approximately 2 years day shift both breakfast and tated residents had a choice be, alternate entrée or a food er and supper meals. The food f a fast food sandwich such as ger or chicken patty and ated residents were asked if gular, alternate or a basket at ious meal and it was recorded w what to prepare and serve. a.m. E1 was interviewed a o the breakfast meal. E1 was P designation that was written the Dietary Manager (DM) ., E1 and the DM explained extra calories being added	F	325			

Facility ID: 00764

If continuation sheet Page 26 of 39

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL		FORM MB NO.	01/09/2017 APPROVED 0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG	i	COM	PLETED
		245569	B. WING			08/:	26/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	7:23 a.m. E3 was represented a serving half and	esponsible for serving ents and wheeled a cart with (such as milk, juice, coffee) E3 stated she gave residents wanted. When asked about and half for breakfast, she yed to the residents on pureed residents; R9 was not one of eceived half and half, a	F	325			

Facility ID: 00764

If continuation sheet Page 27 of 39

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			FORM / MB NO. (X3) DATE	01/09/2017 APPROVED 0938-0391 E SURVEY PLETED
		245569	B. WING			08/5	26/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-0/2010
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	and the supplement place to address that The Medication Adr was reviewed to de much supplement t meal replacement. read, "Give nutrition replacement when 12 pm % eaten 6 pt boxes for documen p.m., and 6 p.m.) at percentage eaten for times, nurses' initia the boxes for perce was recorded. It was supplement was giv reflected the meal p the supplement cor On 8/25/16 at 2:02 interviewed and stat the initials meant R only that the % eater monitored but the s On 8/25/16 at 2:06 Nurse (LPN 1) was gave the supplement she thought it was the supplement whenever CNA 3 was interview and stated R9 fed for resident where the had poor vision. We snacks to the resident	t meal replacement was in at. ministration Record (MAR) termine how often and how he resident consumed as a The August 2016 MAR entry hal supplement as meal meal is refused 8 am % eaten m % eaten." The MAR had ting all 3 meals (8 a.m., 12 nd boxes for documenting or all 3 meals. In the boxes for ls were documented and in entage eaten a percent amount as unclear when the ven and if the percentage percentage or percentage of	F3	325			

If continuation sheet Page 28 of 39

	MENT OF HEALTH	FO	RM	01/09/2017 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE	SURVEY PLETED
		245569	B. WING			08/2	26/2016
NAME OF F	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST ALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE
F 325 F 363 SS=E	dietary department The Dietitian was in p.m. and reported the change the end of a loss, but was still wi The Dietitian stated response to the res asked about which received from the N to ask the DM. The specific plan or any which foods from the offered and/or which When asked about meal replacement a was unclear, she st she is getting the su 483.35(c) MENUS I ADVANCE/FOLLOW Menus must meet t residents in accorda dietary allowances of Board of the Nation Academy of Scienc and be followed. This REQUIREMEN by: Based on observat resident and staff in ensure menus were	hy snacks being sent from the for R9. terviewed on 8/25/16 at 3:08 he resident had a significant luly 2016 with some weight thin her ideal body weight. the NIP was initiated in ident's weight loss. When interventions the resident IIP, she stated she would have Dietitian verified there was no documentation regarding e NIP the resident would be h ones she would accept. the supplement used as a and the documentation that ated, "I would want to know if upplement." MEET RES NEEDS/PREP IN	F 3		F363 Dietary staff were in-serviced on Tuesd September 20th, 2016 and reviewed di extensions, how to read them and use	lay	9/20/16
	sample (R38, R18,	R13, R37) who were diets and for 8 of 28 residents			them, and to stress the importance of following them to assure appropriate		

Facility ID: 00764

If continuation sheet Page 29 of 39

0	<u>RS FUR MEDICARE</u>	& MEDICAID SERVICES			<u>OMB NO</u> .	0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE	E SURVEY PLETED
		245569	B. WING _		08/2	26/2016
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 363	in the Stage 2 sam R19, R4) who were the survey. Two of (R33, R36) compla and was not adequ Findings include: 1.The menu was no prescribed pureed a. On 8/22/16 the m pureed green bean supper meal. The regular diets to be a Meal observations and 5:50 p.m. All 4 were observed to re pureed tomatoes in Cucumbers and ray are not recommend residents on pureed should be homogen like in texture (Ame Level 1 pureed diet Care Manual. www <http: www.nutritio<br="">January 10, 2011.) b. On 8/24/16 the m whipped squash as meal to residents o directed residents o</http:>	ple (R9, R16, R7, R48, R21, e served meal baskets during 28 Stage 2 sampled residents ined the menu lacked variety	F 36	foods for mechanically altern provided for those residents such diets. In-servicing was the Consultant Dietician. Co Dietician and/or Dietary Mgr responsible for nutritional ar resident's who reside here. Use of the menu substitution reviewed on Tuesday Septe 2016 in-service with emphas following the diet extensions food is unavailable will a sub made. In this case the subsi documented and explained substitution log and posted of board. It was stressed that v designated for Pureed diets as noted on the diet extensis that R38, R18, R13, R37, ar appropriate and safe vegeta Two vegetable choices will b when a resident chooses the alternate. A resident's right t vegetable offerings will be h is when the main menu is ch residents who chose meal b survey observation, R9, R16 R21, R19, R4 as well as, an resident who chooses the ba be offered two vegetable ch be encouraged to enjoy a very A fourth week will be added seasonal menu cycles. The cycles will be reviewed and foods that are not as popular residents being switched out	requiring completed by nsultant , will also be halysis for all in log was mber 20th, sis given to be configured by the menu regetables be followed on the menu regetables be followed ons to ensure e provided bles. be offered e basket meal o refuse onored, as it nosen. The 7 askets during 5, R7, R48, y other asket meal will bices and will egetable. to the current current menu updated with r with	

Facility ID: 00764

If continuation sheet Page 30 of 39

				<u> </u>	<u>MB NO.</u>	0938-039
DEFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · ·	SURVEY PLETED
	245569	B. WING			08/26/2016	
IDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
/ING CENTER						
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE
ntinued From pag	ge 30	F 3	63			
e menu also directed residents of termelon. All 4 re- eived pureed pin- termelon. All 4 re- eived pureed pin- termelon. The Dietary Mana 55 a.m. The surv d asked about the nu. The DM look re was no squas s on the menu in ified residents or ved pureed corn eapple was served termelon; she did ostitution was ma Residents who se ved vegetables i Residents had a rée, alternate en ner and supper r pice for the supper a corn dog and fr he menu was cre esidents (R9, R1 ved meal basket se residents wer R9 was sitting at her meal on 8/24 ident was served ich consisted of a	cted residents on pureed diets d watermelon. The menu n regular diets to be served esidents on pureed diets eapple instead of pureed ager (DM) was interviewed at reyor showed her the menu e squash that was on the ed at the menu and stated h and she was not aware it stead of corn. The DM n pureed diets had been . The DM stated pureed ed in place of pureed d not explain why the ide. elected meal baskets were not n accordance with the menu. choice of selecting the main trée or a meal basket for the neals. The meal basket er meal on 8/22/16 consisted ies. The vegetable according eamy cucumbers. None of the 6, R7, R48, R21, R19, R4) s were served a vegetable; e served corn dogs with fries. the dining room table waiting 4/16 at 11:41 a.m. The a food basket at 11:42 a.m., a hot dog in a bun and waffle			continue offering a basket meal at a lunch and supper. Also the possibili adding a salad bar will be discussed way to increase fresh vegetables ar fruits and providing a greater variety foods at each dinner and supper. The Dietary Mgr will attend Residen Council to receive input from reside regarding their wishes as far as chat they would like to see made to the r R33 and R36 will be specifically interviewed by the Dietary Mgr to ob their input on menu revisions. R33's suggestions such as fewer sandwic and more fresh fruits and vegetable be considered for menu revision. All four weeks of both seasonal cyc be reviewed for menu adequacy. Ou updated after resident input, a nutrit analysis will be completed for the m relevant macro and micro-nutrients. These analysis reports will be place the diet extension binders for each cycle. All facility policy and procedure mar will be reviewed by Dietary Mgr and Consultant Dietician to assure that to most current and up-to-date policies place and outdated policies are arcl Dietary Mgr/Consultant Dietician wil visually audit pureed diet meals of a residents who receive them for pro vegetable choice/options and for off of a vegetable when residents choic the basket meal. This will be done 3 for 1mo, and then 1x/wk for 1 mo un	ty of d as a nd y of nt ints anges menu. otain s ines ines is will les will les will nce tional nost is d in menu nuals /or the s are in hived. I all per fering ce is 3x/wk ntil	
	DEFICIENCIES RRECTION IDER OR SUPPLIER /ING CENTER SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS ntinued From page e menu also director be served pureed part e asked about the nu. The DM look re was no squas s on the menu in ified residents or ved pureed corn e apple was served termelon; she did ostitution was ma Residents who se ved vegetables i Residents had a rée, alternate en ner and supper r pice for the supper a corn dog and fr he menu was cre- esidents (R9, R1 ved meal basket se residents wer R9 was sitting at her meal on 8/24 ident was served ich consisted of a s. The resident ver	PEFICIENCIES RRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245569 IDER OR SUPPLIER /ING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ntinued From page 30 e menu also directed residents on pureed diets be served pureed watermelon. The menu acted residents on regular diets to be served termelon. All 4 residents on pureed diets eived pureed pineapple instead of pureed termelon. The Dietary Manager (DM) was interviewed at 55 a.m. The surveyor showed her the menu d asked about the squash that was on the nu. The DM looked at the menu and stated re was no squash and she was not aware it s on the menu instead of corn. The DM ified residents on pureed diets had been ved pureed corn. The DM stated pureed eapple was served in place of pureed termelon; she did not explain why the ostitution was made. Residents who selected meal baskets were not ved vegetables in accordance with the menu. Residents had a choice of selecting the main rée, alternate entrée or a meal basket for the ner and supper meals. The meal basket pice for the supper meal on 8/22/16 consisted a corn dog and fries. The vegetable according he menu was creamy cucumbers. None of the esidents (R9, R16, R7, R48, R21, R19, R4) ved meal baskets were served a vegetable; se residents was not served a vegetable; vegetable on the menu and available on the	RRECTION IDENTIFICATION NUMBER: A. BUILD 245569 B. WING IDER OR SUPPLIER ////////////////////////////////////	VEFICIENCIES RRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING 245569 B. WING IDER OR SUPPLIER ID /ING CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID ntinued From page 30 F 363 e menu also directed residents on pureed diets be served pureed watermelon. The menu excted residents on regular diets to be served termelon. All 4 residents on pureed diets eived pureed pineapple instead of pureed termelon. The Dietary Manager (DM) was interviewed at 55 a.m. The surveyor showed her the menu d asked about the squash that was on the nu. The DM looked at the menu and stated re was no squash and she was not aware it s on the menu instead of corn. The DM ified residents on pureed diets had been ved pureed corn. The DM stated pureed eapple was served in place of selecting the main rée, alternate entrée or a meal basket for the ner and supper meals. The meal basket for the ner and supper meal on 8/22/16 consisted a corn dog and fries. The vegetable according he menu was creamy cucumbers. None of the esidents (R9, R16, R7, R48, R21, R19, R4) ved meal baskets were served a vegetable; se residents were served are vegetable; se residents were served are vegetable; se resident was not served a vegetable; se resident was not served a vegetable; vegetable on the menu and available on the	IFFICIENCIES RRECTION (X1) PROVIDERSUPPLIER IDENTIFICATION NUMBER: 245569 (X2) MULTIPLE CONSTRUCTION A BUILDING IDER OR SUPPLIER ING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST HALSTAD, MN 56548 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFRECTIVE ACTION MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS FLAN OF CORRECTION (EACH OFRECTIVE ACTION SHOLD CROSS REFERENCE) TO THE APPROPH DEFICIENCY AG Internet From page 30 F 363 e menu also directed residents on pureed diets be call areadion. All 4 residents on pureed diets be called residents on regular diets to be served termelon. F 363 The Dietary Manager (DM) was interviewed at 55 a.m. The SURVEYOR showed by the subacted corr. The DM stated pureed eapple was served in place of pureed termelon. F 363 The Dietary Manager (DM) was interviewed at 55 a.m. The surveyor showed her the menu asked about the squash that was on the nu. The DM looked at the menu and stated regarding their wishes as far as cha they would like to see made to the residents who selected meal baskets were not wed pureed corr. The DM stitution was made. F 363 Residents who selected meal basket for the ner and supper meal on 8/22/16 consisted a corn dog and fries. The vegetable according ther meal on 8/22/16 at 11:42 a.m., ch consisted of a hot dog in a bun and waffle s. The resident was not served a vegetable se residents who reserved a vegetable so rand or difficat 11:42 a.m., ch consisted of a hot dog in a bun and	EFFICIENCIES RRECTION (X1) PROVIDERSUPPLIER (LA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) MULTIPLE CONSTRUCTION A. BUILDING (X4) MULTIPLE CONSTANT (X4) MULTI

Facility ID: 00764

If continuation sheet Page 31 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/26/2016	
NAME OF	PROVIDER OR SUPPLIER	-	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 363	 1/ E1) was interview employed in the fac and she cooked on dinner meals. E1 st for the regular entre- basket for the dinner basket consisted of a hot dog, hamburg French fries. The DM was intervia and verified that wh baskets for dinner a not customarily ser Two residents re and that menu was a. R33 was intervia and on 8/26/16 at 7 she was not satisfie there were too man fresh foods, as well breaded foods. R33 meals were inconsi served at times. Or "There are a lot of t - fried foods, heavy hamburgers and pa greasy. The grilled menu repeats about not a lot of variety. about food I like: sa they say it can't be change; you know variety." 	10 p.m., the Cook (Employee wed; she stated she had been sility for approximately 2 years day shift both breakfast and ated residents had a choice ée, alternate entrée or a food er and supper meals. The food a fast food sandwich such as ger or chicken patty and ewed on 8/24/16 at 11:55 a.m. then residents ordered food and supper, a vegetable was ved, but stated it could be. ported they tired of the menu not adequate. ewed on 8/22/16 at 5:00 p.m. 245 a.m. The resident reported ed with the menu. R33 stated by sandwiches, not enough as too many fried and 8 reported the portions and stent with small meals being the 8/26/16, the resident stated, hings on the menu I don't like	F	363	Dietary Mgr and/or Consultant Diet will bring audit results to QA comm further review/suggestions for six n	ittee for	

Facility ID: 00764

If continuation sheet Page 32 of 39

		AND HUMAN SERVICES				FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING	i		08/:	26/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 363	 9:45 a.m. and state good and he got tire foods. On 8/23/16 a R36 was leaving the dinner meal. When reported he had a h good and he was tire c. Review of the mean was in place; every 3 weeks. d. A nutritional analy requested from the The DM stated she and there was no n The DM was interviand stated the men menu and had beer menu with the introd The DM stated the shorter with foods r stated the current n and a winter/spring The DM provided tw to meeting resident did not know which e. One of the policie undated; it was title nutritional needs of least restrictive mead documented as procedure was titled and the current of the shorter with foods r stated the current n and a winter/spring The DM provided tw to meeting resident did not know which 	ed the food was not always ed of being served the same at approximately 12:05 p.m. e dining room following the asked how the meal was, he namburger, that it was not very	F	363			

If continuation sheet Page 33 of 39

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		245569	B. WING	 	08/	26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 363 F 366 SS=E	"Calories: Each day approximately 1600 portions sizes it rea follow what was one This is in response concern that too mu change will address small appetites, but resident who are ow encouraged to ask trained to offer mor at nutritional risk." e. The Dietitian was 3:08 p.m.; she state indicated between 2 provided daily throu one in place. The D menus; she verified been completed an shortened from 5 to she used general g protein a day, 5 frui combined, and con Dietitian stated staf vegetables at every Dietitian stated whe residents should be were on the menu i 483.35(d)(4) SUBS NUTRITIVE VALUE Each resident recei substitutes offered residents who refus	d's menu will provide d's menu will provide 1800 calories. "Under d, "Overall portion sizes will ce considered small portions. to the continued resident uch food is provided. This a not only our residents with also should help with our verweight. Resident will be for seconds and staff will be e, especially to those resident a interviewed on 8/25/16 at ed the undated policy that 2000-2400 calories would be ugh the menu was the current vertian stated she wrote the a no nutritional analysis had d that the cycle menu was o 3 weeks. The Dietitian stated uidelines of 5-6 ounces of t and vegetable servings sistent carbohydrate. The f were to always offer r noon and evening meal. The en meal baskets were served; e served the vegetables that n addition to the meal basket. TITUTES OF SIMILAR ves and the facility provides of similar nutritive value to	F 3	3		9/20/16

Facility ID: 00764

If continuation sheet Page 34 of 39

		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED	
		245569	B. WING _			08/26/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2			
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 366	Continued From pa	ige 34	F 3(66			
	resident and staff ir ensure alternates w residents in the Sta R11, R9) when resi served. Findings include: 1. R9 was admitted According to a 7/6/7 the resident's curre dementia, anxiety, o gastro-esophageal On 8/24/16 at 8:15 observed sitting at the resident had both w and was drinking co one piece of toast w cheese on top and ate none of the back toast and drank hal not offered anything resident was observed for 8/24/16, dinner 8/24 resident was not see meals and she was the meal or in betw the milk exchange a	reflux disease. a.m., the resident was the dining room table. The vater and coffee at the table offee. The resident was served with a slice of American 1 piece of bacon. The resident con, ate half of the piece of f of the cup of coffee. R9 was g else to eat or drink. The ved wheeling herself out of the		F366 A policy and procedure to substitutes are offered of value to residents who r will be written. Staff were this policy on Tuesday S Consultant Dietitian. Stat the need to encourage i alternates of similar nutr foods a resident is not e Recipes were reviewed adequate portions of foo are being served to resid A listing of acceptable a was created to assist stat high calcium foods to re drink milk (attached). RS alternate high calcium foo does not accept milk. An does not drink milk will b calcium food in place of R9 will be served an alter of similar nutritive value not except juice. All other consistently refuse juice alternate food that is sim value. Fruits such as pir mandarin oranges, pead fresh citrus fruits will be day on the beverage can offer those to residents of juice. Lists will be posted in th alternate food sources f vegetables; and protein dietary staff and nursing Planned alternate entree	of similar nutritive efuse food served e in-serviced on Sept 20th by the aff were trained on ntake and to offer ritive value of trating. to assure od components dents. Iternates for milk aff in offering other sidents who don't e will be served bods when she hy resident who be offered a high milk. ernate food option when she does er residents who e will be offered an hilar in nutritive heapple tidbits, ches, and pears or available each rt so that staff can who do not accept e dining room with ro milk; juice; available to all staff.		

Facility ID: 00764

		& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY IPLETED	
		245569	B. WING _		08/26/2016		
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 366	Continued From pa	ge 35	F 36	66			
	gastro esophageal The resident's seat of the dining room of needed meal assist On 8/22/16 the sup beginning at 5:01 p melt sandwich, a to cucumbers in a sm for dessert. The res little during the mea had finished eating, sandwich or puddin few bites of the cuc member asked the The resident stated resident was not off or at any other time consumed less that 3. R11 was admitte "Admission Record including dementia, arthritis. The reside the portion of the di residents who need On 8/22/16 the sup beginning at 5:01 p chicken salad sand salad between slice cucumbers in a sm pistachio pudding for	reflux disease, and weakness. assignment was in the portion designated for residents who tance. per meal was observed, .m. R1 was served a patty mato slice, creamy all bowl and pistachio pudding sident was observed to eat al. At 5:45 p.m. the resident . R1 had not eaten any of the ig. The resident had eaten a sumbers. At this time, a staff resident how the meal was. I, "You can have it." The fered an alternate at this time e during the meal. She		extension forms for every dinn- supper for both menu cycles. R1, R11, R22, and R33 will be alternate foods/meals when the eating their chosen meal. Staff trained on the need to monitor these residents, along with all of when it is seen a residents is n well at a meal, alternates will b with the residents needing to b 4 of these residents were visite CDM to obtain updated food pr as the resident is able to provid CDM and/or designee will obse 5 meals a week and document these 4 residents in particular, residents as well, have been or alternates when not eating. The and/or designee will complete observation over a 2 week peri report findings at the next QA r tool was created to track findin will be reminded that real food emphasized over supplements All staff in-serviced on the basi service value of offering alterna meal/foods when a meal is not eaten. It was emphasized that residents deemed at risk or ne assistance should be of focus with cues and encouragement with the expedient offering of a meal/foods when not eating. R R22, and R33 in particular will	offered ey are not were intake of others, and ot eating e offered e asked. All ed by the references, de. The erve at least whether but other fered e CDM this od and will neeting. A gs. All staff should be c customer ate being those eding every meal to eat and lternative 1, R11,		
	5:47 p.m. the reside nurse aide approac her if she was finish	ucumbers and pudding. At ent had finished eating and a hed the resident and asked ned. Although the resident had y a third of the small meal		encouraged and assured altern These procedures will be imple all residents as it has the poter affect any/all at any time. An audit addressing the above	emented for Itial to		

Facility ID: 00764

TATEMENT OF DEFICIEI	ICIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY	
			A. BUILDI	NG _		001		
		245569	B. WING _			08/	26/2016	
NAME OF PROVIDER OI	SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
HALSTAD LIVING C	ENTER				33 FOURTH AVENUE EAST ALSTAD, MN 56548			
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
at any tim asked at by the nu 4. R22 w. "Admission including depression hospice as was in the for reside On 8/22/ beginning salad sar between tomato sl The resic pick at the finished as chicken as ate less t not offeren meal. 5. R33 w. Current of Minimum anemia, I Review of dated 6/2 demonstri with a Brit score of	the resider the during is the end of rse aide. As admitted on Record dementia re disorde ervices. The portion of the sup at 5:01 p dwich (th 2 slices of the sup of the sup at 5:01 p dwich (th 2 slices of the and p ent was of the meal. At ating. R2 alad sand d an alter as admitted iagnoses. Data Set heart failu f the quar 7/16 and ated the r of (score y intact p	age 36 at was not offered an alternate the meal or when she was f the meal if she was finished ed to the facility on 1/28/16; the " documented diagnoses , breast cancer, and major er. The resident received The resident's seat assignment of the dining room designated needed meal assistance. oper meal was observed, o.m. R22 was served a chicken in layer of chicken salad f bread), creamy cucumbers, a bistachio pudding for dessert. observed during the meal to t 5:45 p.m. the resident had 22 had not eaten any of the dwich or pudding. The resident of the meal. The resident was mate at any time during the ed to the facility on 1/30/15. , from the 4/4/16 quarterly (MDS) assessment, included re, and high blood pressure. terly Minimum Data Set (MDS) annual MDS dated 1/11/16 resident was cognitively intact ew for Mental Status (BIMs) of 13-15 consistent with er the Resident Assessment	F 3	66	be completed by the Dietary Mgr CDM twice a week for the next 6 (attached). The CDM will report to the QA co quarterly for 6 months with audit and corrective actions taken and for solutions that are sustainable	months mmittee results		

If continuation sheet Page 37 of 39

		AND HUMAN SERVICES			FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245569	B. WING		08/:	26/2016
NAME OF !	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 366	reported alternates did not eat what was stated, "I have to as want to eat what the the time, but they d 6. CNA1 and CNA2 8/25/16 at 4:42 p.m they would do if a re Both CNAs failed to alternate food if the served. Their comm -CNA1 stated, "If the encourage them to give them Boost (m -CNA2 stated, "I wo CNA1). If the reside them as much we c If they don't eat, we to get fluids in." The Director of Nur on 8/26/16 at 7:40 a should offer an alte eat their meal prior as Boost. The Dietary Manag 8/26/16 at 8:00 a.m should be offered if during meals. The I entrée was included and supper meals, vegetable exchange the menu. The DM have 2 vegetables I supper but a numbe	age 37 were not offered to her if she as served at the meals. R33 sk for something else if I don't ey serve me. I hate to ask all on't come around and offer." 2 were interviewed together on a The CNAs were asked what esident did not eat their meal. o say that they would offer an e resident did not eat what was nents were as follows: he resident is dependent we eat. If they won't eat, then we utritional supplement)." ould do the same thing (as ent is dependent, we feed can, I will put in the extra effort. e get Boost. We always need rsing (DON) was interviewed a.m. and stated the CNAs ernate food if a resident did not to offering a supplement, such her (DM) was interviewed on a and verified alternates is residents had poor intake DM verified that an alternate d on the menu for the dinner but an alternate starch and e were not always included on stated the menus used to listed for every dinner and er had been removed when iced from a 5-week cycle if every 5 weeks) to a 3-week	F 36			

Facility ID: 00764

If continuation sheet Page 38 of 39

		AND HUMAN SERVICES			FORM	01/09/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY PLETED
		245569	B. WING		08/3	26/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 366	approximately a yea purchased a deep to baskets (hot dog, hother fast food type rings or potato chip dinner and supper. The Dietitian was in p.m. and stated ress alternate if they did When asked if alter example included of was an alternate er food basket option the dinner and supp	M stated this occurred ar ago when the facility fat fryer and rolled out the food hamburger, chicken patty or e of sandwich, with fries, onion bs) as another meal option for terviewed on 8/25/16 at 3:08 sidents should be offered an not eat what was served. Intervet were planned, for on the menu, she stated there thrée on the menu and the fast was available every day for per meals. The Dietitian were not always planned for	F 36			

Facility ID: 00764

If continuation sheet Page 39 of 39

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245569 _{Y1}	B. Wing	Y2	11/21/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAD LIVING CENTER		133 FOURTH AVENUE EAST		
		HALSTAD, MN 56548		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	vi	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix Reg. #	F0166 483.10(f)(2)	Correction	ID Prefix F0248 Reg. #	Completed	ID Prefix Reg. #	F0280 483.20(d)(3), 483.10(k) (2)	Correction Completed
LSC		09/16/2016	LSC	09/16/2016	LSC		09/16/2016
ID Prefix	F0325	Correction	ID Prefix F0363	Correction	ID Prefix	F0366	Correction
Reg. #	483.25(i)	Completed	483.35 Reg. #	Completed	Reg. #	483.35(d)(4)	Completed
LSC		09/16/2016	LSC	09/16/2016	LSC		09/16/2016
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	_	Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC	-		LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		_
REVIEWE		REVIEWED BY (INITIALS) GA/MM	date 12/05/2016	SIGNATURE OF SURVEYOR 32603		DATE 11,	/21/2016
REVIEWE	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 8/26/2016			ANY UNCORRECTED DEFICIENCIES TED DEFICIENCIES (CMS-2567) SEN			es 🗌 no	

DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			CENTERS FOR MED	ICARE & MEDICAID SERVICES	
					ND TRANSMITTAL	ID: KMB9	
	PART I -	TO BE COMP	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00764	
1. MEDICARE/MEDICAID PROVID (L1) 245569	DER NO.	3. NAME AND AI (L3) HALSTAD				 TYPE OF ACTION: <u>2 (L8)</u> Initial 2. Recertification 	
2.STATE VENDOR OR MEDICAID	NO.	(L4) 133 FOURTH AVENUE EAST			3. Termination4. CHOW		
(L2) 075740300		(L5) HALSTAD,	MN		(L6) 56548	5. Validation 6. Complaint 7. On-Site Visit 9. Other	
5. EFFECTIVE DATE CHANGE OF	FOWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey After Complaint	
(L9)	04/2016 (124)	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	· · ·	
 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 	04/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Rav	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC	(L10)	04 SNF	07 A-Kay 08 OPT/SP	12 RHC	16 HOSPICE	09/30	
2 AOA 3 Other		04 5111	00 01 1/51	12 1410	it nost ice		
11LTC PERIOD OF CERTIFICATIO	ON	10.THE FACILITY	Y IS CERTIFIED	AS:			
From (a):		A. In Complia			And/Or Approved Waivers Of T		
To (b) :			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit	
		*			3. 24 Hour RN	7. Medical Director	
12. Total Facility Beds	44 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN		
13. Total Certified Beds	44 (L17)	X B. Not in Cor	npliance with Prog	gram	5. Life Safety Code	9. Beds/Room	
		Requirements	and/or Applied V	Waivers:	* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
44							
(L37) (L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Tammy Williams, HFE I	NEII	(09/16/2016	(L19)	Mark Meath,	Enforcement Specialist 09/23/2016 (L20)	
PA	ART II - TO BE (COMPLETED	BY HCFA RE	GIONAL	OFFICE OR SINGLE ST	FATE AGENCY	
19. DETERMINATION OF ELIGIB	ILITY		APLIANCE WITH	I CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)		
X 1. Facility is Eligible to	Participate	RIGI	HTS ACT:		2. Ownership/Contro 3. Both of the Above	l Interest Disclosure Stmt (HCFA-1513)	
 Facility is not Eligib 							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEN	MENT 2	4. LTC AGREEN	IENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION 07/01/1991	BEGINNINC	6 DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure 00		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ment 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	(120)		03-Risk of Involuntary Termination	n OTHER	
25. EIC ENTEROION DITE.		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change	
	ľ		(L44)			00-Active	
(L27)	B. Rescind Su	spension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	20	. DETERMINATION		DATE			
51. KO KLEEN I OF CM5-1559	32	. DETERMINATION	VI ALE KU VAL	DALE			
	(L32)			(L33)	DETERMINATION APPR	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 19, 2016

Ms. Angela Nelson, Administrator Halstad Living Center 133 Fourth Avenue East Halstad, MN 56548

RE: Project Number S5569027

Dear Ms. Nelson:

On August 8, 2016, a standard 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. In addition, at the time of the August 8, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number .

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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 8, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division 705 Fifth Street NW, Suite A Bemidji, Minnesota 56601 Telephone: (218)308-2104 Fax: (218)308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 13, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 13, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

Halstad Living Center August 19, 2016 Page 3

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

Halstad Living Center August 19, 2016 Page 4

signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 4, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 4, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Halstad Living Center August 19, 2016 Page 6

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

ato Comston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		FOI	RMAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB	IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DATE SURVEY OMPLETED
		245569	B. WING		8/04/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				133 FOURTH AVENUE EAST	
HALSIA	D LIVING CENTER			HALSTAD, MN 56548	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 000	INITIAL COMMENT	ſS	F 00	D	
	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as liance.			
F 221 SS=D	revisit of your facilit validate that substa		F 22	1	9/8/16
	physical restraints i discipline or conver	e right to be free from any mposed for purposes of nience, and not required to medical symptoms.			
	by: Based on observat review the facility fa free from physical r (R22) reviewed for Findings include: R22's quarterly Min 7/18/16, identified F impaired and had d dementia, depressi MDS identified R22 staff for activities of a wheelchair for loc	NT is not met as evidenced tion, interview and document hiled to ensure residents were estraint for 1 of 3 residents restraints. imum Data Set (MDS) dated R22 was severely cognitively iagnoses which included on and reduced mobility. The required total assistance from daily living (ADL's) and used comotion. The MDS did not obysical restraint during the 7		It is the policy of Halstad Living Center that the resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience. Wheelchair brakes for R22 are determined to be a restraint due to R22 inability to propel her wheelchair when a brake is engaged. Staff were immediate counseled regarding the inappropriate u of wheelchair brakes and the risk to potentially restrain the resident. This alleged deficient practice has the potent to affect all residents that reside here. Staff will be re-educated on proper use wheelchair brakes when a resident is at	s ly se ial
		DER/SUPPLIER REPRESENTATIVE'S SIGN		TITLE	(X6) DATE

Electronically Signed

08/26/2016

PRINTED: 09/16/2016

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/04/2016	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAI	D LIVING CENTER				33 FOURTH AVENUE EAST ALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	revealed R22 had s and required total a ADL's. R22's care p space chair and red locomotion to destin lacked documentation brakes. Review of R22's me restraint assessment Review of R22's pro 7/29/16, revealed n wheelchair restraint On 8/3/16, R22 was 7:01 a.m. to 8:14 a. seated in a tilt in sp to have her eyes op R22's right wheelch a.m. R22 remained wheelchair brake lo the floor and her lef foot rest. At 7:28 a. the tilt in space cha her eyes open. R22 footrest of the wheel right arm and grabb the wheelchair. R22 wheelchair with her move forward as th locked. R22 placed began to repeated	rriod. rrent care plan dated 7/17/16, severe cognitive impairment ssistance from facility staff for plan revealed R22 used a tilt in quired assistance with hations. R22's care plan ion to lock her wheelchair edical record revealed no nts. pgress notes form 2/4/16, to o documentation on use of a t for R22. s continuously observed from m. At 7:01 a.m. R22 was ace chair. R22 was observed ben and was looking around. hair brake was locked. At 7:22 seated in the tilt in space eyes closed and her cked. R22's right foot was on t foot was on the wheelchair m. R22 remained seated in ir near the nurses station with 2 placed her right foot on the plachair, reached down with her bed hold of the right wheel of 2 attempted to propel her right arm and was unable to e wheelchair brake was both feet on the floor and y tap both feet on the floor.	F 2	221	to propel him/her self and when the resident is 'parked' on an uneven si Staff were reeducated to ask reside they are ok with using a brake to ke them from rolling back on an unever surface (such as the dining room)o turning the front small wheel of the slightly to attempt to stop the rolling before applying the brake. DON visually inspected all residents wheelchairs who are able to propel themselves where the locking of a l becomes a restraint. Visual audits will be performed by DON/Designee 3x/wk for 1 month a then randomly thereafter to assure continued compliance. All staff were reeducated on or before 9/8/16 reg the proper use of wheelchair brake. Restraint Policy and Procedures wi added to new employee orientation DON and/or designee will report fin of the audits to the QA Committee quarterly until 100% compliance is attained.	urface. ent if eep r to try chair , s in brake and e arding s. Il be . The	
	The director of nurs	sing (DON) was observed to ed in the wheelchair, but did					

If continuation sheet Page 2 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	not approach R22. registered nurse (R near R22 at the nur approach her or dis At 7:30 a.m. R22 re space chair, with th reached down with wheelchair forward, wheelchair forward, wheelchair forward, wheelchair. Rehab R22 in the wheelch provide assistance. behind R22, verbali she would move R2 RA-A reached down R22's right wheel a wheelchair to her ro room, RA-A stated back into her tilt in s R22 to lean forward blue slacks to pull h of the chair. RA-A th and assisted R22 ir common area by th lock R22's wheelch tilt in space wheelch tilt in space wheelch the common area. On 8/3/16, at 7:36 a practice to lock a br on how she had be was able to propel I but at times could n wheelchair brakes v a.m. R22 remained wheelchair and pro down the 300 wing R22 and stated it w	Ige 2 Nursing assistant (NA)-A and N)-A were observed to walk reses station, but did not sengage the wheelchair brake. emained seated in the tilt in le right brake engaged. R22 her right hand to the nd attempted to propel the . R22 was unable to move her aid (RA)-A was observed near air at that time, and did not At 7:31 a.m. RA-A stood ized to the medication nurse 22 back in her wheelchair. In and released the brake on nd assisted R22 in the born. Upon entering R22's R22 needed to be scooted space chair. RA-A then asked d and used the back of R22's her buttocks towards the back hen adjusted R22's head rest in her wheelchair back to the the nurses station. RA-A did not air brake. R22 remained in the hair propelling herself around a.m. RA-A stated it was usual rake on R22's chair depending en doing. RA-A stated R22 herself in the tilt in space chair not and that's when R22's were locked for safety. At 8:05 seated in the tilt in space pelled her wheelchair 2 doors hallway. NA-A approached ras almost breakfast time. wheelchair around and	F 2	221			

If continuation sheet Page 3 of 35

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAD LIVING CENTER					133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	brought R22 back to nurses station wher residents wheelcha and engaged R22's immediately walked a.m. RN-A walked of stood at R22's left st the upcoming break walk away from R22 left wheelchair brak practical nurse (LPI wheelchair and adm LPN-A attempted to forward, and was un with the brake enga- brake and moved R NA-A took R22 to th her to the table. NA engaged R22's righ in her tilt in space w 8:14 a.m. to 8:54 a. wheelchair brake re- during the entire bro On 8/3/16, at 8:16 a propel herself in the not recall unlocking LPN-A stated R22's be locked as she co stated R22 needed destinations, but co distance. At 8:54 a. disengaged her righ of the dining room i nurses station. NA- wheelchair brake. A R22 and offered an	b the common area by the e she stopped next to another ir. NA-A then reached down left wheelchair brake and away from the area. At 8:10 over to R22 in the wheelchair, ide and spoke with her about tfast meal. RN-A proceeded to 2, had not disengaged R22's e. At 8:13 a.m. licensed N)-A approached R22 in her ninistered medications to R22. move R22's wheelchair ged. LPN-A disengaged the 22 toward the dining room. the dining room, and brought -A reached down and t brake. R22 remained seated theelchair at the table from m. to eat breakfast. R22's mained engaged/locked eakfast meal. the LPN-A stated R22 could thit in space chair and could R22's wheelchair brake. wheelchair brakes should not ould "meander" around. LPN-A assistance to reach uld wheel herself a fair m. NA-A approached R22, th brake and assisted R22 out not the common area by the A did not engage/ lock R22's activity aid (AA)-A approached opportunity to fold towels. A-A assisted R22 out of the	F2	221			

If continuation sheet Page 4 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAD LIVING CENTER					133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	Continued From pa	ge 4	F 2	221			
	able to propel her w times. RN-A stated wheelchair would b also stated R22 did for the use of a rest current care plan di wheelchair brakes. On 8/3/16, at 8:25 a (DON) confirmed R wheelchair and indi wheelchair brake w for R22. The DON s to follow a residents expect staff not to b The DON also state was locking resider indicated she had o they were locking b this practice had be On 8/3/16, at 9:25 a routinely lock R22's away. NA-A stated before, but felt as a lock R22's brake. N herself in her whee go to a specific des impairment. NA-A s wheelchair brake w independently prop locked the brake ou A facility policy and Restraint, revised 5 a physical restraint	ould prevent her from elling herself. NA-A stated she					

If continuation sheet Page 5 of 35

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	· · ·	E SURVEY	
id plan c	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	COMPLETED		
		245569	B. WING		08/04/2016		
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST	E		
IALSTA	D LIVING CENTER			HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 221	equipment which w freedom of movem The policy directed	ge 5 ould restrict an individuals ent or access to ones body. staff physical restraints were en ordered or in a medical	F 2:	21			
F 241 SS=D		AND RESPECT OF	F 24	41		9/8/16	
	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.						
	by: Based on observat review the facility fa experience with the	NT is not met as evidenced tion, interview and document ailed to provide a dignified e utilization of a catheter for 1)reviewed with a catheter.		It is the policy of Halstad Living that the facility shall promote car residents in a matter and in an environment that maintains or er each resident's dignity and indivi R31 had an indwelling catheter p 7/5/16 due to urinary retention. It	e for hances duality. laced on was		
	5/23/16, identified F impairment, require activities of daily liv lower extremetity in identified R31 was and bladder.	imum Data Set (MDS) dated R31 had moderate cognitive ed extensive assistance with all ing (ADLs) and had upper and npairment. The MDS also always incontinent of bowel		noted by surveyors a strong urine R31's bedroom and bathroom. R31's catheter bag will be chang weekly and the catheter bag will cleaned daily with a solution of o white vinegar and three parts wa control the urine odor per facility This tx will be completed by the l	ed be ne part ter to policy. ₋PN on		
	an indwelling cathe inability to void for e was to monitor for o Foley catheter mon weeks. The care pl	ted 7/7/16, identified R31 had ter placed 7/5/16, for an extended periods of time. Staff odorous urine, change the thly and the Foley bag every 2 an failed to identify additional cleaning or irrigating the		duty. R31's room has been thoro striped and cleaned by Environm Service staff, including the walls, baseboards, furniture, bed, bath curtains which has eliminated the Environmental Service staff will o to clean R31's room daily. This d	ental floors, coom and e odor. continue		

Facility ID: 00764

If continuation sheet Page 6 of 35

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
IND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	COM	COMPLETED	
		245569	B. WING		•	04/2016
NAME OF PROVIDER OR SUPPLIER HALSTAD LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIF	CODE	
				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 241	Continued From pa	ge 6	F 24	1		
	catheter.	0		practice has the potential	to affect any/all	
				residents with indwelling of		
		p.m. R31 was in his wheelchair of the TV. R31 had a catheter		staff reeducated on or bef proper care of indwelling		
		cloth bag on the side of his		facility policies and procee		
	wheelchair. R31's	bedroom had a strong, foul,		DON/Designee checked r	ooms of all	
	concentrated urine	odor.		residents with catheters for		
	On 8/3/16 at 7:15	a.m. R31 was observed in bed		proper cleaning of cathete urine collection cylinders.		
		heter collection bag inside a		care will be added to new		
	cloth bag which sat	on the floor next to his bed. A		orientation.		
		to measure urine output and		DON/Designee will visual		
		ere on the back of R31's toilet. d bathroom continued to have		all residents rooms who h catheters 3x/wk for 1 mor		
		entrated urine odor.		randomly thereafter for co compliance. Results of au	ontinued	
	On 8/3/16, at 8:26 a	a.m. registered nurse (RN-B)		reviewed by the QA comm		
	stated R31 required	d extensive assistance with all		review/suggestions until 1	00%	
	activities of daily liv	ing (ADLs) and was not a		compliance attained.		
	0	ker. She stated she was aware and stated the urine odor				
		R31's catheter was placed.				
	She stated she felt	there was sediment in the				
		causing the odor and the				
		gone through to check what ine odor. She stated R31's				
		nicker" because he was on				
		RN-B stated R31 didn't drink				
		n contributed to R31's urine				
		stated there were things they limit R31's urine odor such as				
		ar, or changing the catheter				
	entirely. She state	d the catheter is changed				
		g twice per month. RN-B				
		assistant's (NA's) wash R31's				
		soap and water twice a day needed if they noticed odor.				
		g was responsible for the				
		ment. She confirmed the last				

If continuation sheet Page 7 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING	i		08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	Continued From pa	ge 7	F2	241	I		
	time nursing chang 7/20/16.	ed the catheter bag was on					
	assistant (TMA)-B s decision maker as l stated R31 was tota cares. TMA-B state had an odor becaus stated his urine in tl started with the initi stated when she no would have to chan know if she told the before today. She s odor. She stated sh with soap and wate confirmed she didn it back up.	a.m. trained medication stated R31 was not a good his cognition wasn't good. She ally dependent on staff for of R31's urine was dark and se he didn't drink enough. She he bag is dark and the odor ation of the catheter. She bticed the odor the nurses ge it. TMA-B stated she didn't nurse about R31's odor stated all catheters had an he washed R31's perineal area r, emptied R31's foley bag and 't rinse out the bag but closed					
	interview RN-B stat bag, emptied the bay washed surrounding She confirmed NA's it was emptied. She responsible for irrig evening or night shi know where the odd stated the odor hun She stated when shi day it was really bay changed his catheted talked to the night r her to irrigate the tu stated she felt it hel						
		a.m. NA-D stated she noticed day and shelly told the nurse.					

If continuation sheet Page 8 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	She stated she was soap and water and She confirmed she emptied it. She stat totally dependent of she agreed with Sh had the same odor. On 8/3/16, at 12:25 urine odor in R31's confirmed the urine from the pitcher and toilet which were us R31's catheter bag from the cloth bag of cc of light brown uri urine odor was from stated she felt R31' there were no "chur don't rinse the bag have caused more have rinsed the bag bag, and rinsed the used 2 different bag control drops or effe control R31's urine On 8/3/16, at 1:10 p totally dependent of alterations in his the communication. Sh staff to follow the pl of urine odor. She s R31 had urine odor Review of, "Your Ri Federal and Minnes Residents Bill of Rig	shed R31's perineal area with d emptied the catheter bag. didn't rinse the bag after she ed R31 was confused and in staff for cares. She stated elly and she felt all catheters p.m. RN-B confirmed strong bedroom and bathroom. RN odor in the bathroom was d urinal on the back of R31's sed to measure urine from . RN lifted R31's catheter bag on the floor that contained 120 ine and confirmed the strong in R31's catheter bag. She s urine looked pretty good as hks in it". She stated the NA's after emptying which would odor. She stated they could g after emptying, used a leg bag every day with vinegar, gs alternating, or try odor erdent tablets in the bag to odor. 0.m. DON stated R31 was in staff for cares and had bught processes and e stated she would expect an of care and R31 to be free stated she was not aware that until today. ghts Under The Combined	F 2	41			

If continuation sheet Page 9 of 35

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		G		COMPLETED	
		245569	B. WING _		08/04/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 241	Continued From pa	ge 9	F 24	1			
		and environment that ces your dignity and respect in our individuality.					
F 280 SS=D	483.20(d)(3), 483.1	•	F 28	0		9/8/16	
	incompetent or othe incapacitated under	r the laws of the State, to ing care and treatment or					
	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.						
	by: Based on observat review the facility fa for 1 of 1 residents catheter.	NT is not met as evidenced tion, interview and document ailed to revise the plan of care (R31) reviewed with a		It is the policy of Halstad Liv complete a comprehensive within seven days after com comprehensive assessment the IDT that includes the atte	care plan pletion of the ; prepared by ending		
	Findings include: R31's quarterly Min			physician, a registered nurse appropriate staff in discipline			

Event ID: KMB911

Facility ID: 00764

If continuation sheet Page 10 of 35
TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI		LE CONSTRUCTION	MB NO.	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· /				PLETED
		245569	B. WING	i		08/0	04/2016
NAME OF F	PROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 280	Continued From pa	age 10	F 2	280			
		R31 had moderate cognitive			if practicable, the participation of th	ne	
		ed extensive assistance with all			resident, family, or legal representa		
	•	ing (ADLs) and had upper and			and periodically reviewed and revis	sed by a	
		npairment. The MDS also			team of qualified persons with eac	h	
		always incontinent of bowel			assessment.		
	and bladder.				Corrective action taken for R31 wa		
	R31's care plan dat	ted 7/7/16, identified R31 had			immediately change the catheter b 8/3/16. Prior to survey exit, an aud		
		ter placed 7/5/16, for an			conducted to ensure appropriate	it was	
		extended periods of time. Staff			interventions are care planned for	R31.	
		odorous urine, change the			This alleged deficient practice has	the	
		thly and the Foley bag every 2			potential to affect any/all residents	with	
		cility staff was aware of odor			indwelling catheters.		
		ple interventions they could			All staff will be in-serviced on follow		
		lan failed to identify additional ninimizing the urine odor for			facility policy to report immediately licensed nursing when, if any, futur		
	R31.				is noted for all residents with induc		
					catheters. Also reeducated regard		
	On 8/1/16, at 5:00 p	p.m. R31 was in his wheelchair			rinsing out collection cup with wate		
	in his room in front	of the TV. R31 had a catheter			each use, and emptying in the toile	et.	
		cloth bag on the side of his			Licensed staff reeducated regardir		
		bedroom had a strong, foul,			proper care of urine collection bag		
	concentrated urine	odor.			treatment of rinsing the bag with 1 vinegar and 3 parts water, allowing		
	On 8/3/16 at 7:15 :	a.m. R31 was observed in bed			water to remain in the bag for a mi		
		heter collection bag inside a			of 15-30mins per facility policy. Sta		
		on the floor next to his bed. A			in-servicing was completed on or b		
	small silver pitcher	to measure urine output and			9/8/16.		
		ere on the back of R31's toilet.			DON inspected all residents rooms		
		d bathroom continued to have			have indwelling catheters for odors		
	a strong, foul, conc	entrated urine odor.			reviewed the individual care plans	of	
	On 8/3/16 at 8.26	a.m. registered nurse (RN-B)			those residents for proper care of catheters with interventions for cat	heter	
		are of R31's urine odor and			care and odors.		
		or started soon after R31's			All staff reeducated on proper cath	eter	
		d. She stated she felt there			care and resolving odors for any		
	was sediment in the	e tube that could be causing			residents' that have a catheter. All		
		theter should be gone through			staff were in serviced on or before		
	to check what was	causing the urine odor. She			Proper catheter care will be added	to all	

Facility ID: 00764

If continuation sheet Page 11 of 35

STATEMEN [®]	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CON	PLETED	
		245569	B. WING		08/	04/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 280	stated R31's urine he was on thickene didn't drink enough R31's urine odor pathings they could he odor such as irriga the catheter entirel changed monthly a RN-B stated the nu R31's perineal area day with cares and odor. RN-B stated the insertion and e last time nursing cl on 7/20/16. On 8/3/16, at 10:54 assistant (TMA)-B dark and the odor a catheter. She stated the nurses would he stated she didn't kin R31's odor before had an odor. She s perineal area with a foley bag and confi bag but closed it ba On 8/3/16, at 11:28 interview RN-B stated bag, emptied the b washed surroundir She confirmed NA4 it was emptied. Shi responsible for irrig evening or night shi	was "a little thicker" because ed liquids. RN-B stated R31 influids which contributed to roblem. She stated there were lave tried to limit R31's urine ting with vinegar, or changing y. She stated the catheter is and the bag twice per month. Ursing assistant's (NA's) wash a with soap and water twice a las needed if they noticed nursing was responsible for quipment. She confirmed the hanged the catheter bag was 4 a.m. trained medication stated R31's urine in the bag is started with the initiation of the ed when she noticed the odor have to change it. TMA-B how if she told the nurse about today. She stated all catheters stated she washed R31's soap and water, emptied R31's irmed she didn't rinse out the ack up. 8 a.m. during a follow-up ted NA's open the catheter hag and closed the bag and hig skin with soap and water. 1's didn't rinse out the bag after e stated the LPN was gating with vinegar during the hift. RN-B stated she didn't lor was coming from and	F 280		ored to e does not all for odor ks, then s, then ms will be		

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAI	D LIVING CENTER				33 FOURTH AVENUE EAST ALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	changed his catheter talked to the night in her to irrigate the tur- stated she felt it hel On 8/3/16, at 11:48 R31's urine odor to She stated she was soap and water and She confirmed she emptied it. On 8/3/16, at 12:25 urine odor in R31's confirmed the urine from the pitcher and toilet which were us R31's catheter bag from the cloth bag of cc of light brown uri- urine odor was from stated she felt R31' there were no "chur- don't rinse the bag have caused more have rinsed the bag bag, and rinsed the used 2 different bag control drops or effec- control R31's urine On 8/3/16, at 1:10 p (DON) stated she w plan of care and R3 stated she was not odor until today.	d and she should have er at that time. She stated she nurse the other night and had ubing with plain water and lped. a.m. NA-D stated she noticed day and she told the nurse. shed R31's perineal area with d emptied the catheter bag. didn't rinse the bag after she p.m. RN-B confirmed strong bedroom and bathroom. RN e odor in the bathroom was d urinal on the back of R31's sed to measure urine from . RN lifted R31's catheter bag on the floor that contained 120 ine and confirmed the strong n R31's catheter bag. She 's urine looked pretty good as nks in it". She stated the NA's after emptying which would odor. She stated they could g after emptying, used a leg bag every day with vinegar, gs alternating, or try odor erdent tablets in the bag to odor.	F 2	280			
	Review of facility po	olicy and procedure titled, Care					

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	IPLE CONSTRUCTION		. 0938-039 E SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED		
		245569	B. WING		08/	/04/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,		DE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE HALSTAD, MN 5654				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
F 280		/04, revealed it was a policy of	F 2	80				
	the facility to develop individualized care plans for residents which would address assessed needs and interventions in place based upon assessment.							
	483.20(k)(3)(ii) SEF PERSONS/PER CA	RVICES BY QUALIFIED ARE PLAN	F 2	82		9/8/16		
	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.							
	This REQUIREMEN	NT is not met as evidenced						
	Based on observation, interview and document review the facility failed to implement care planned interventions for 2 of 3 residents (R22, R31) reviewed for repositioning and urinary incontinence.			develop individua on assessed nee breakdown and p	Halstad Living Center to alized care plans based eds to prevent skin provide care by qualified			
	Findings include:				dance with each plan of care. No negative noted from alleged			
	R22's quarterly Minimum Data Set (MDS) dated 7/18/16, identified R22 was severely cognitively impaired and had diagnoses which included dementia, depression and reduced mobility. The MDS identified R22 required total assistance from staff for activities of daily living (ADL's). The MDS further identified R22 was at risk for pressure ulcer development, required pressure reduction devices for chair and mattress surfaces.			deficient practice Corrective action having the poten Residents with sp repositioning, and been audited by (8/4/16) and prior by the DON. Measures put int	e. taken for all residents tial to be affected:			
	Review of R22's current care plan dated 7/17/16, identified R22 was at high risk for pressure ulcer development due to impaired mobility and incontinence. R22's care plan identified current			All staff were re-e the policy and pro turning, repositio	educated by the DON on ocedure of following the ning, toileting program d care plan for each			

Facility ID: 00764

If continuation sheet Page 14 of 35

						NO. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		B) DATE SURVEY COMPLETED	
		245569	B. WING			08/04/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CI	ITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER			133 FOURTH AVENU HALSTAD, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE	
F 282	Continued From pa	ige 14	F 2	32			
	pressure air relieving p directed facility staf reposition at least e with 2 staff assistar care plan revised 7, assist R22 with toile and to check R22's hours for total bowe R22 remained seat 6:45 a.m. to 9:20 a. minutes. On 8/3/16 observations 7:01 a observed to be rep checked/changed. in her tilt in space w through 9:20 a.m. v buttocks or offer/pro On 8/3/16, at 9:25 a been repositioned a shift helped her get R22 was supposed checked and chang because of skin bre needed total assista toileting needs. On 8/3/16, at 9:29 a total assistance with and changing at least On 8/3/16, at 10:40 interview NA-A stat	a.m. 9:20 a.m. R22 was not positioned or R22 was observed to remain wheelchair from 7:01 a.m. without offloading from her ovision of toileting services. a.m. NA-A stated R22 had last at 6:45 a.m. when the night to be repositioned and ged at least every 2 hours eakdown. NA-A stated R22 ance with repositioning and a.m. NA-C stated R22 required h repositioning and checking		deficient practi affect all reside be re-educated reference to in each resident of Corrective acti ensure the alle not recur: DON visual audits 3 continue 4x/mo randomly there compliance is		s for or vill s will ien	

If continuation sheet Page 15 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
HALSTAI	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	responsible for report changing R22 and y done so. On 8/3/16, at 10:51 hospice NA note re- to R22 by the hospic required assistance and changing at lead confirmed R22's can directed staff to assist repositioning and to On 8/3/16, at 10:59 (DON) stated she et care plan for the assist and checking and of hours. Review of facility por Planning, revised 4, the facility to develor residents which wor and interventions in assessment. R31's quarterly Min 5/23/16, identified F bowel and bladder ap ressure ulcers and device for his chair. R31's care plan dat the potential for alter to impaired physical integrity, incontinen	 a.m. RN-A confirmed the vealed no cares were provided ice aid. RN-A stated R22 a.m. the positioning, checking ast every 2 hours. RN-A tree plan was current and sist R22 with assessed oileting needs. a.m. the director of nursing expected staff to follow R22's issessed needs of repositioning changing at least every 2 blicy and procedure titled, Care /04, revealed it was a policy of p individualized care plans for uld address assessed needs in place based upon imum Data Set (MDS) dated R31 was always incontinent of and was at risk for developing d had a pressure relieving 	F	282			
		required extensive assist of 2 position in bed and chair every essary.					

If continuation sheet Page 16 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/(04/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ige 16	Fź	282			
	12/7/15, identified F pressure ulcers as assistance with ADI	sessment (CAA) dated R31 was at risk for developing R31 required extensive Ls, was always incontinent of and had weight loss.					
	Kardex Report which assistant care guide	/ form titled Visual/Bedside ch served as a nursing e, directed staff to turn and ry two hours when in bed and					
	to 8:00 p.m. identifie or repositioned in h p.m. R31 was seate room table waiting f Resident's chair wa 5:47 p.m. licensed p administered R31's was fed his meal by 6:29 p.m. NA-E tilte slightly and wheeled the day area. At 7:1 shirt down over his exposed. NA-G sta we'll have to put hin check with my partr R31's head was ha	ation on 8/2/16, from 5:21 p.m. ed R31 had not been offered is chair. On 8/2/16, at 5:21 ed in the dining room at dining for his evening meal. as in an upright position. At practical nurse (LPN)-B a medication. At 6:00 p.m. R31 y nursing assistant (NA)-H. At ed R31's wheelchair back d him from the dining room to 15 p.m. NA-G pulled R31's belly as his lower belly was ted out loud to herself, "I think m to bed soon, I'll have to ner and see what she says." nging forward and to the left, . At 8:00 p.m., after surveyor vas laid down.					
	assigned to R31's of stated she didn't kn repositioned, but sta supper. NA-G state	o.m. NA-G stated she was was care for that evening. She now exactly when R31 was last ated it was sometime before ed R31 was supposed to be 2 hours when in his chair or					

If continuation sheet Page 17 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/(04/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	bed. She confirmed repositioning. On 8/3/16, at 8:26 a confirmed R31's ca have been repositio confirmed the reaso repositioning was to skin breakdown. Sh extensive to total as repositioning. RN-E able to offload pres his chair without sta On 8/3/16, at 10:54 assistant (TMA)-B s keep R31's skin inte every 2 hours and to bottom. She stated every 2 hours. She dependent on staff repositioning. She s staff to turn and rep On 8/3/16, at 11:48 plan directed them hours to prevent op On 8/3/16, at 1:10 p (DON) stated R31 to pressure ulcers and 2 hours. The DON extensive assistant totally dependent of stated she would ex- care and reposition the development of	a.m. registered nurse (RN)-B are plan and stated R31 should oned every 2 hours. She on for every 2 hour offload pressure and prevent the confirmed R31 required ssistance from staff for 8 confirmed R31 would not be usure from his bottom while in aff assistance. • a.m. trained medication stated current interventions to act were to reposition R31 use barrier cream on his R31 should be repositioned stated R31 was totally for bed mobility and stated R31's care plan directed position R31 every 2 hours. • a.m. NA-D stated R31's care to reposition him every 2 pen areas. • o.m. the director of nurses was at risk for developing d required repositioning every confirmed R31 required ce with repositioning and was n staff for repositioning. She spect staff to follow the plan of R31 every 2 hours to prevent	F 2	82			

If continuation sheet Page 18 of 35

						0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION	· · ·	E SURVEY IPLETED	
		245569	B. WING _			04/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 282	Continued From pa		F 28	32			
F 312	Positioning, revised 3/09, revealed it was the facility's procedure to evaluate resident repositioning needs, develop an individualized care plan based on assessed need to prevent skin breakdown, promote circulation and provide pressure relief for residents. 483.25(a)(3) ADL CARE PROVIDED FOR		F 31	12		9/8/16	
	DEPENDENT RES		ΓJ			9/0/10	
	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.						
	by:	NT is not met as evidenced		5242			
	Based on observation, interview and document review the facility failed to implement every two hours check and change incontinence program for 1 of 3 residents (R22) reviewed with incontinence.			F312 It is the policy of Halstad Livin provide ADL care to dependen who are unable to maintain ne activities of daily living for gro- nutrition, turning/repositioning	nt residents ecessary oming, , toileting		
	Findings include:	imum Data Sat (MDS) datad		and personal hygiene & oral h independently.			
	7/18/16, identified F impaired and had d	imum Data Set (MDS) dated R22 was severely cognitively iagnoses which included		Corrective action taken for R2 educated staff on the importa following the plan of care rega	nce of arding		
	dementia, depression and reduced mobility. The MDS identified R22 required total assistance from staff for activities of daily living (ADL's). The MDS			turning, repositioning, incontir dependent residents. DON/De visually monitored these area	esignee s for		
	further identified R2 and was not on a to	2 was frequently incontinent vileting program.		compliance for all residents w potential to be affected by the deficient practice prior to and	alleged		
	7/24/16, directed fa	rrent care plan revised acilty staff to assist R22 with ery 2 hours and to check R22's		exit on 8/4/16. No negative ou identified by the alleged defici Measures put into place to en	itcomes ent practice.		

Facility ID: 00764

If continuation sheet Page 19 of 35

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TI	PLE CONSTRUCTION		0938-039 SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED	
		245569	B. WING		08/0	04/2016	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	DDE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 312	Continued From pa	age 19	F 31	2			
		ery 2 hours for total bowel and		alleged deficient practice do All staff were reeducated im the DON on the policy and p	mediately by		
Review of a quarterly nursing ass 7/24/16, identified R22 was freque of bowel and bladder and required assistance from staff with incontin directed by the care plan.		R22 was frequently incontinent er and required total aff with incontinence cares as		following the turning, reposit toileting program per individ plan for each resident. All st re-inserviced regarding the for reference to individualized	ioning, ualized care aff will be use of I-pads d care plan		
	toileting. On 8/3/16 observations 7:01 a observed to be toil	and 35 minutes without , during continuous a.m. 9:20 a.m. R22 was not eted. On 8/3/16 at 9:25 a.m. NA)-A stated R22 was up in the a.m.		for each resident on/before 2016. Corrective actions will be mo ensure the alleged deficient not recur: DON/Designee wi visual audits 3x/wk for 4 we continue 4x/month for 1 mon randomly thereafter until 100	onitored to practice will Il conduct eks. Audits will oth and then		
	space chair. At 7:24 a tilt in space chair 7:31 a.m. rehabilita in the wheelchair to R22 was boosted b RA-A. RA-A adjuste assisted R22 in her common area by th not observed to che incontinent brief. At	a.m. R22 was seated in a tilt in 8 a.m. R22 remained seated in near the nurses station. At tion aide (RA)-A assisted R22 o her room. Once in her room, back in her wheelchair by ed R22's head rest and r wheelchair back to the ne nurses station. RA-A was eck and/or change R22's t 8:05 a.m. R22 remained space wheelchair. NA-A		compliance is maintained co Any negative patterns will be QA committee for further review/recommendations.	onsistently.		
	approached R22, s breakfast time. NA- assistance with toil practical nurse (LP administered her m R22 to the dining ro not offered assistan checking and chan dining room until 8: R22 out of the dinin	tated to R22 that it was almost -A did not offer R22 eting. At 8:13 a.m. licensed N)-A approached R22 and nedications. NA-A then took bom for breakfast. R22 was noce with repositioning or with ging. R22 remained in the 54 a.m. NA-A then assisted ng room and back to the ne nurses station. Activity aid					

If continuation sheet Page 20 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/(04/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	(AA)-A offered R22 room. R22 accepte towels for folding. A seated in her wheel staff had been obse check and changing the activity room. N approach R22 or of 9:19 a.m. AA-A app all of the towels, an go back to her room then assisted R22 i where she turned o NA-B entered R22's At 9:20 a.m. NA-A a stand with the mech into the bathroom w removed R22's inco with urine on the bat On 8/3/16, at 9:25 a been repositioned a shift helped her get R22 was supposed checked and chang because of skin bre needed total assista toileting needs. On 8/3/16, at 9:29 a total assistance with and changing at lea On 8/3/16, at 10:40 interview NA-A state NA had assisted wit there for cares that R22's hospice aide	to go fold towels in the activity d and was provided a pile of at 9:04 a.m. R22 remained lchair in the activity room. No erved to offer repositioning or g. At 9:16 a.m. NA-A entered A-A was not observed to fer assistance with cares. At proached R22, she had folded d asked her if she wanted to n, R22 had replied yes. AA-A n her wheelchair to her room on R22's call light. NA-A and s room with the mechanical lift. and NA-B assisted R22 to hanical lift and brought R22 with the mechanical lift. NA-A ontinent brief which was wet ack portion of the brief. a.m. NA-A stated R22 had last at 6:45 a.m. when the night s up for the day. NA-A stated to be repositioned and ged at least every 2 hours eakdown. NA-A stated R22 ance with repositioning and a.m. NA-C stated R22 required h repositioning and checking ast every 2 hours. a.m. during a follow up ed she thought R22's hospice th repositioning when he was morning. NA-A stated when	F3	12			

If continuation sheet Page 21 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAI	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	not done so. NA-As verbally communication	ge 21 A and was not aware he had stated she would usually ate with the hospice aid on R22 though did not do it this	F 3	312			
	practice for residen was for the NA's to cares were provide NA leaving. RN-A s revealed no cares w hospice aid. RN-A s	a.m. RN-A stated the usual ts who received hospice care verbally communicate what d for R22 prior to the hospice tated the hospice NA note were provided to R22 by the stated R22 required assistance checking and changing at least					
	(DON) stated she e care plan for her as	a.m. the director of nursing expected staff to follow R22's esessed need of repositioning changing at least every 2					
F 314 SS=D	bathroom/commoderevealed the policy residents were to be per care plan. 483.25(c) TREATM		F 3	314			9/8/16
	resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores reco	prehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and					

Facility ID: 00764

If continuation sheet Page 22 of 35

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II TI	U PLE CONSTRUCTION		0938-039		
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	. ,	G		PLETED		
		245569	B. WING		08/0	04/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE		
F 314	Continued From pa prevent new sores	-	F 31	4				
	by: Based on observat review the facility fa hour repositioning f risk for and with a h of 3 residents (R31 development who r repositioning. Findings include: R22's quarterly Min 7/18/16, identified F impaired and had d dementia, depressi MDS identified R22 staff for activities of further identified R2 ulcer development, devices for chair ar Review of R22's cu identified R22 was development due to incontinence. R22's pressure ulcer inter pressure air relieving p directed facility staff reposition at least e with 2 staff assistant Review of a tissue f the skin and its sup	NT is not met as evidenced tion, interview and document ailed to implement every two for 1 of 3 residents (R22) at history of pressure ulcers and 1) at risk for pressure ulcer equired staff assistance with imum Data Set (MDS) dated R22 was severely cognitively liagnoses which included, on and reduced mobility. The required total assistance from f daily living (ADL's). The MDS 22 was at risk for pressure required pressure reduction and mattress surfaces. rrent care plan dated 7/17/16, at high risk for pressure ulcer o impaired mobility and s care plan identified current rventions in place included a ng mattress to R22's bed and a bad to recliner. R22's care plan f to assist R22 to turn and every 2 hours and as needed nce.		F314 See F282 It is the policy of Halstad Living Ce ensure that a resident who enters of facility without a pressure sore, do develop pressure sores unless the individual's condition demonstrates they were unavoidable; and a resid having pressure sores receives ne treatment and services to promote healing, prevent infection and prev sores from developing. R22 contin be at high risk for potential develop of pressure ulcers and needs assis with turning/repositioning. R22 doe currently have any open/reddened No negative outcomes arose from alleged deficient practice. Correctiv action taken for all residents having potential to be affected by the alleg deficient practice: Residents with se turning/repositioning plans will be v audited by the DON/Designee 3x/v 1mo and 1x/wk for another month, ensure compliance is achieved and maintained. All staff will be re-educated regard following the individualized POC for turning/repositioning each resident before September 8th, 2016. Any r patterns will be reported to QA con for further review/recommendation	the es not s that lent cessary ent new ues to oment stance es not areas. the ve g the ged pecific <i>r</i> isually vk for to d ng r on or negative nmittee			

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	<u>.</u>		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	dated 7/26/16, iden and was able to tole repositioning. Review of a skin wo revealed R22 contri from staff for daily o revealed R22 was a breakdown, was fre and bladder and reo needs. Review of a skin wo revealed R22 had 3 (non-blanchable ery coccyx which meas 0.75 cm. The note r mattress was imple Review of a skin wo revealed R22's pres Review of a skin wo revealed R22's pres Review of a skin wo revealed R22 was a development. Review of physiciar R22 had been adm overall declining co Review of R22's pro 7/29/16, revealed R22 required a turning a preventative skin ca ulcer development, notes revealed the	ound note dated 4/24/16, nued to require assistance cares and needs. The note at high risk for skin equently incontinent of bowel quired staff assistance for ound note dated 6/21/16, 3 stage I pressure ulcers ythema of intact skin) on her sured 0.75 centimeters (cm) x revealed a pressure relieving emented to aid in healing. ound note dated 7/1/16, ssure ulcers were healed. ound note dated 7/17/16, at high risk for pressure ulcer n note dated 7/21/16, revealed hitted to hospice care due to ondition and dementia. ogress notes form 2/4/16, to veekly skin assessment from 2's skin was intact. R22 and repositioning program and are due to risk for pressure . In addition R22's progress	F3	314			

If continuation sheet Page 24 of 35

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/16/2016 APPROVED 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF PRO	OVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAD I	IVING CENTER				33 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	by the second state of the	ing was applied by the night R22 continued to have an occyx which was a pressure ealed an air alternating d on R22's bed for pressure I to require a turning and 22's pressure ulcer on her since air mattress was placed. and 35 minutes without (3/16, during continuous a.m. 9:20 a.m. R22 was not eted. On 8/3/16 at 9:25 a.m. IA)-A stated R22 was up in the	F	314			

If continuation sheet Page 25 of 35

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245569 B. WING 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **133 FOURTH AVENUE EAST** HALSTAD LIVING CENTER HALSTAD, MN 56548 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 25 F 314 R22 repositioning. At 8:10 a.m. Registered nurse (RN)-A walked over to R22 and spoke with her about breakfast. RN-A then walked away from R22 without offering R22 repositioning. At 8:13 a.m. licensed practical nurse (LPN)-A approached R22 and administered her medications. LPN-A moved R22 toward the dining room and NA-A took R22 to the dining room. LPN-A and NA-A did not offer repositioning or assistance with cares at that time. R22 remained seated in her tilt in space wheelchair at a table in the dining room from 8:14 a.m. to 8:54 a.m. At 8:54 a.m. NA-A assisted R22 out of the dining room and back to the common area by the nurses station. Activity aid (AA)-A offered R22 to go fold towels in the activity room. R22 accepted and AA-A provided a pile of towels for folding. At 9:04 a.m. R22 remained seated in her wheelchair in the activity room and folded towels. No staff was observed to offer repositioning. At 9:16 a.m. NA-A entered the activity room and was not observed to approach R22. At 9:19 a.m. AA-A assisted R22 in her wheelchair to her room where she turned on R22's call light. NA-A and NA-B entered R22's room with the mechanical lift. At 9:20 a.m. NA-A and NA-B assisted R22 to stand with the mechanical lift and brought R22 into the bathroom. When NA-A removed R22's brief, her buttocks had multiple deep creases on both buttocks, and the skin on her buttocks was dark pink in color. On 8/3/16, at 9:25 a.m. NA-A stated R22 had last been repositioned at 6:45 a.m. when the night shift got her up for the day. NA-A stated R22 was supposed to be repositioned every 2 hours because of skin breakdown. NA-A stated R22 had some skin breakdown at least a month ago and had healed quickly once they gave her a new

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 26 of 35

PRINTED: 09/16/2016

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	mattress. NA-A stat assistance with repo On 8/3/16, at 9:29 a total assistance with hours. NA-C stated her buttocks within had healed quickly. On 8/3/16, at 10:40 interview NA-A state hospice NA had ass he was there for ca when R22's hospice responsible for repo aware he had not d would usually verba hospice aid on wha not do that at this til and was not able to repositioned. On 8/3/16, at 10:51 practice for resident was for the NA's to cares were provided NA leaving. RN-A cor revealed no cares w hospice aid. RN-A s with repositioning a stated R22 continue breakdown and had her coccyx in 6/16 w RN-A stated she fel R22's coccyx were because they had no pressure relieving no an intervention at the	ted R22 needed total ositioning. a.m. NA-C stated R22 required h repositioning at least every 2 R22 had skin breakdown on the last month or two and it a.m. during a follow up ed she had thought R22's sisted R22 to reposition when res that morning. NA-A stated e aide would come he was positioning. NA-A was not one so. NA-A stated she ally communicate with the t was done for R22 though did me. NA-A stated she was busy	F 3	314			

If continuation sheet Page 27 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245569	B. WING	i		08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HALSTAI	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	toileting needs. On 8/3/16, at 10:59 (DON) confirmed R ulcers. The DON st follow R22's care pl repositioning at leas Review of facility po Positioning, revised facility's procedure repositioning needs care plan based on skin breakdown, pro pressure relief for re R31's quarterly Min 5/23/16, identified F impairment, require activities of daily livi lower extremity imp identified R31 was and bladder and wa pressure ulcers and device for his chair. R31's care plan dat the potential for alte to impaired physica integrity, incontinen and multiple medica also identified R31	a.m. the director of nursing 22 was at risk for pressure ated she expected staff to lan for the assessed need of st every 2 hours. blicy and procedure titled, 3/2009, revealed it was the to evaluate resident s, develop an individualized assessed need to prevent omote circulation and provide esidents. imum Data Set (MDS) dated R31 had moderate cognitive ed extensive assistance with all ing (ADLs) and had upper and pairment. The MDS also always incontinent of bowel as at risk for developing d had a pressure relieving ted 7/7/15, identified R31 had eration in skin integrity related al mobility, impaired skin rce, poor safety awareness al problems. The care plan required extensive assist of 2 position in bed and chair every	F	314			
		sessment (CAA) dated R31 was at risk for developing					

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	pressure ulcers as assistance with ADI bowel and bladder a Review of R31's pro- clinical assessment 5/23/16, which inclu- evaluate pressure u- placed him at risk for break down. R31 w bladder, had a histor groin and arm pit, w incontinence care a repositioned every for The undated facility Kardex Report which assistant care guide reposition R31 ever chair. Continuous observa- to 8:00 p.m. identified or repositioned in h p.m. R31 was seated room table waiting for Resident's chair wa 5:47 p.m. licensed p administered R31's was fed his meal by 6:13 p.m. NA-I brok handed half to him. his cookie on was co At 6:29 p.m. NA-E to slightly and wheeled the day area, aster R31 continued seat	R31 required extensive Ls, was always incontinent of and had weight loss. ogress notes revealed a t had been completed on uded a BRADEN (a scale to ulcer risk) score. R31's score or pressure ulceration and skin ras incontinent of bowel and ory of boils on the buttocks, was dependent upon staff for and R31 was to be turned and	F	314			

If continuation sheet Page 29 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´				E SURVEY PLETED
		245569	B. WING	·		08/	04/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	as his lower belly w loud to herself, "I th bed soon, I'll have to see what she says. forward and to the I 8:00 p.m., after sum laid down. Observator were red with crease thighs. At that time, blanchable and the buttocks were from On 8/2/16, at 7:56 p assigned to R31's of stated she didn't kn repositioned, but sta supper. NA-G state repositioned every 2 bed. She stated be chair she considered confirmed she did r She stated she didr pressure ulcers be nurses. On 8/3/16, at 8:26 a confirmed R31's ca have been reposition confirmed R31's lass (the ability of the sk structures to endured without adverse effet 12/3/15, and identified repositioning. She ca and that R31 was a ulcers. She stated F history of maceration confirmed the reason	 as exposed. NA-G stated out ink we'll have to put him to to check with my partner and "R31's head was hanging left, off of the head rest. At veyor intervention, R31 was tion revealed R31's buttocks as in buttocks and upper RN-B stated the redness was scars observed on the R31's history of boils. b.m. NA-G stated she was was care for that evening. She low exactly when R31 was last ated it was sometime before ad R31 was supposed to be 2 hours when in his chair or cause R31 was asleep in his ed that a refusal. She not offer R31 repositioning. It know if R31 was at risk for cause that was up to the a.m. registered nurse (RN)-B are plan and stated R31 should oned every 2 hours. She is tissue tolerance test (TTT) the effects of pressure, ects) was completed on fied R31 required every 2 hour confirmed R31's Braden score at risk for developing pressure R31 had scar tissue and a on to his bottom. She 	F	314			

If continuation sheet Page 30 of 35

		AND HUMAN SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245569	B. WING			08/(04/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	skin breakdown. Sh and was unable to n confirmed R31 requ assistance from sta confirmed R31 wou pressure from his b without staff assista charge nurse last n and reposition R31 On 8/3/16, at 10:54 assistant (TMA)-B s for developing press a history of skin issi stated current interv- intact were to reposi- use barrier cream of should be reposition R31 was totally dep mobility and reposition confirmed R31 had processes and impa-	he stated R31 was confused make good decisions. She uired extensive to total aff for repositioning. RN-B and not be able to offload bottom while in his chair ance. She confirmed she was ight and expected staff to offer every 2 hours. a.m. trained medication stated she felt R31 was at risk sure ulcers and stated he had ues on his bottom. TMA-B ventions to keep R31's skin sition R31 every 2 hours and on his bottom. She stated R31 ned every 2 hours. She stated bendent on staff for bed cioning. She stated R31's care o turn and reposition R31 a.m. NA-D stated R31 was totally dependent on staff for R31's care plan directed them very 2 hours to prevent open she didn't think R31 was at risk	F 3	14			

If continuation sheet Page 31 of 35

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI 1	TPLE CONSTRUCTION		. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245569	B. WING		08	/04/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 314	Continued From pa	ge 31	F 3	14		
		position R31 every 2 hours to ment of pressure ulcers.				
	Positioning, revised facility's procedure repositioning needs care plan based on	blicy and procedure titled, 3/09, revealed it was the to evaluate resident develop an individualized assessed need to prevent bomote circulation and provide				
F 334 SS=D	•	IZA AND PNEUMOCOCCAL	F 3	34		9/8/16
	that ensure that (i) Before offering the each resident, or the representative rece- benefits and potent immunization; (ii) Each resident is immunization Octobration annually, unless the contraindicated or to immunized during the (iii) The resident or representative has immunization; and (iv) The resident's re documentation that following: (A) That the resider representative was	ives education regarding the ial side effects of the offered an influenza ber 1 through March 31 e immunization is medically he resident has already been his time period;				
		ent either received the tion or did not receive the tion due to medical				

If continuation sheet Page 32 of 35

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245569	B. WING	i		08/(04/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
HALSTAD LIVING CENTER					133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	contraindications or The facility must det that ensure that (i) Before offering th immunization, each legal representative the benefits and po immunization; (ii) Each resident is immunization, unles medically contraind already been immu (iii) The resident or representative has immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po pneumococcal imm (B) That the reside pneumococcal imm the pneumococcal imm the pneumococcal imm years following the immunization, unles	r refusal. evelop policies and procedures in epneumococcal in resident, or the resident's e receives education regarding tential side effects of the offered a pneumococcal so the immunization is icated or the resident has nized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F3	334			

Facility ID: 00764

If continuation sheet Page 33 of 35

PRINTED: 09/16/2016

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED			
		245569	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	04/2016			
NAME OF I	PROVIDER OR SUPPLIER								
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE			
F 334	This REQUIREMEN	NT is not met as evidenced	F 334						
	Based on interview facility failed to ens Conjugate Vaccine- offered to 3 of 5 res recommended by th and Prevention (CE guidelines for PCV Findings include: The CDC guideline PCV13, also called the 13 most comme Advisory Committe (ACIP) recommend age or older receive R28's Immunization indicated the 77 yes Pneumovax dose 1 medical record lack the PCV-13 vaccina CDC. R23's Immunization indicated the 92 yes Pneumovax dose 1 medical record lack the PCV-13 vaccina CDC. R27's Immunization indicated the 85 yes Pneumovax dose 1	s updated 7/16/14, identified Prevnar, protected against on types of pneumonia. The e on Immunization Practices is that all adults 65 years of e a dose of PCV13. In Audit Report dated 8/4/16, ar old had received on 1/4/12. However, the ked evidence R20 was offered ation as recommended by the in Audit Report dated 8/4/16, ar old had received on 9/13/14. However, the ked evidence R23 was offered ation as recommended by the		F334 It is the policy of Halstad Living C provide immunizations as recom- by the ACIP, per their schedule u immunization is medically contra or the resident has already been immunized during a previous tim Corrective action for the resident affected by the alleged deficient p Res #28, 23, & 27 had received Pneumovax dose #1 (PPSV23), being offered a second dose of Pneumovax (PCV13). Consent for were ordered on 8/23/16 and will out to all residents and or family who are affected by the alleged of practice. Consent forms will be s on or before Sept 8th, 2016. Corrective action taken for those having been affected: Residents the criteria will be offered PCV13 PPSV23 upon admission to the find current residents immunization re have been reviewed and physicial orders received to administer per schedule. DON/Designee will vis audit all new admissions until 100 compliance is achieved. This will be completed on or befor 8th, 2016 by DON/Designee. The and procedure has been updated include PCV13 with the current recommended ACIP schedule. Licensed nursing staff to be in set	mended nless the indicated e period. s practice: without orms be sent members leficient ent out residents that meet & acility. All ecords ans ACIP ually D% re Sept e policy I to				

Facility ID: 00764

If continuation sheet Page 34 of 35

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/16/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245569	B. WING			08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAD LIVING CENTER				33 FOURTH AVENUE EAST IALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	On 8/4/16, at 9:34 (DON) who was cu facility's infection co facility policy did no for PCV-13. The DO of a new CDC reco PCV-13, but the DO The DON indicated been discussed; ho standard of practice vaccination to the re vaccine would only physician specifical confirmed the CDC not been followed, a routinely offered the documentation was The facility's Pneum revised 4/09, indication offered the Pneumo to aid in preventing policy, however, dic	a.m. the director of nursing rrently responsible for the ontrol program, confirmed the ot reflect the CDC guidelines ON confirmed they were aware ommendation related to ON did not know the specifics. I the recommendation had owever, it had not become a e to offer/administer the esidents. Currently, the be administered if the Ily ordered it. The DON C guidelines for PCV-13 had as residents had not been e PCV-13. No further s submitted for review. mococcal Vaccine Policy ated all resident would be ovax (Pneumococcal vaccine) Pneumococcal infections. The d not incorporate the new CDC e residents were offered timely	F 3	334	Results of audits will be reviewed b committee quarterly until 100% compliance attained/maintained.	y QA	

Facility ID: 00764

If continuation sheet Page 35 of 35

		AND HUMAN SERVICES & MEDICAID SERVICES		France	RINTED: 08/31/2016 FORM APPROVED MB NO: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245569	B, WING		08/08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HALSTAI	D LIVING CENTER			133 FOURTH AVENUE EAST	
	CUBBAA DV OTA			HALSTAD, MN 56548 PROVIDER'S PLAN OF CORRECTION	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		BE COMPLÉTION
K 000	INITIAL COMMENT	ſS	К 0	00	
	FIRE SAFETY				
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.			
	ONSITE REVISIT (CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
	Minnesota Departm Marshal Division. A Halstad Living Cen- not in substantial co requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National	articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K Health Care Fire In	R THE FIRE SAFETY TAGS) TO:		EPOC	
	State Fire Marshal 445 Minnesota Stre St. Paul, MN 55101	Division eet, Suite 145			
	Or by e-mail to:				
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE
Electron	ically Signed				08/24/2016

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.

		& MEDICAID SERVICES	-				. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245569	B. WING			08	/08/2016	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
HALSTAD LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PRO (EACH	VIDER'S PLAN OF CORR CORRECTIVE ACTION S REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
K 000	Continued From pa Marian.Whitney@s and Angela.Kappenma	state.mn.us	КO	00				
	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:							
	1. A description of what has been, or will be, done to correct the deficiency.							
	2. The actual, or proposed, completion date,							
	responsible for cor	er title of the person rection and monitoring to ence of the deficiency						
	1-story building wit determined to be T 1990 a 1-story add constructed to the was determined to In 1998 a dining ac west of 200 wing a connect to the apa additions are 1 sto were determined to construction. The b zones with 1/2 hour	Iter was built in 1977 as a hout a basement and was ype II (000) construction. In lition to the dining room was east of the original building and be Type II (111) construction. Iddition was constructed to the nd an addition to the south to rtment building. These ry without a basement and be of a Type II (111) building is divided into 5 smoke in fire rated barriers.						
	accordance with N Installation of Sprir The facility has a fi corridor smoke det detection in all con	is sprinkler protected in FPA 13 Standard for the hkler Systems 1999 edition. ire alarm system that includes tection, with additional mon areas, installed in FPA 72 "The National Fire						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	ATE SURVEY OMPLETED	
		245569	B. WING	0	8/08/2016
	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 33 FOURTH AVENUE EAST	
			H	IALSTAD, MN 56548	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 000	automatic fire dete system in accorda Fire Code 2007 ec	edition. Hazardous areas have actors that are on the fire alarm ince with the Minnesota State lition.	K 000		
	Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building.				
		apacity of 44 beds and had a e time of the survey.			
K 029	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: \FETY CODE STANDARD	K 029		8/9/16
SS=E	fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro- the approved auto option is used, the other spaces by sr doors. Doors are field-applied protect 48 inches from the permitted. 19.3. This STANDARD	is not met as evidenced by:			
	revealed that the f proper protection f areas located thro accordance with N (2000 edition) sect conditions could in smoke and flames corridor and adjac untenable, which c	ations and staff interview, it was acility has failed to provide from 2 of several hazardous ughout the facility in IFPA Life Safety Code 101 tion 19.3.2.1. This deficient to the event of a fire, allow to spread throughout the ent areas making them could negatively affect the for 29 of the 40 residents and		The storage room 300 door and soiled utility room 202 door were repaired immediately following the Life Safety Code Survey. Both door closures were repaired and the frames adjusted. Maintenance Director will continue to monitor doors for compliance and repor findings to the Safety Committee quarterly.	t

Facility ID: 00764

If continuation sheet Page 3 of 6

PRINTED: 08/31/2016

	OF DEFICIENCIES	& MEDICAID SERVICES			(3) DATE (COMPL		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	G 01 - MAIN BUILDING 01	COMPL	LETED	
		245569	B. WING		08/08	8/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HALSTAD LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	-	(X5) COMPLETIC DATE	
K 029	· · · ·	age 3 mount of staff and visitors.	K 02	9			
	Findings include:						
	on 08/08/2016 obs	00					
K 050 SS=F	Admiistrator and th	ition was verified by the Facility e Maintenance Engineer. FETY CODE STANDARD	K 05	50	8	3/9/16	
	signal and simulati conditions. Fire dril times under varying on each shift. The and is aware that or routine. Responsib conducting drills is persons who are q Where drills are co 6:00 AM a coded a instead of audible 18.7.1.2, 19.7.1.2 This STANDARD	the transmission of a fire alarm on of emergency fire lls are held at unexpected g conditions, at least quarterly staff is familiar with procedures lrills are part of established ility for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and Innouncement may be used alarms.		One staff member per shift has bee	n		
	interview, it was de to conduct fire drill Safety Code 101(0 12-month period. T affect how staff rea Improperly trained	etermined that the facility failed s in accordance with NFPA Life 0), 19.7.1.2, during the last This deficient practice could act in the event of a fire. staff would affect the safe D residents and undetermined		assigned with the Safety Director to ensure that fire drills are conducted appropriately. Fire drills will not be conducted at shift change. Fire drill reports will be reviewed with the QA Safety Committees quarterly and rep to the Administrator monthly to ensu- compliance.	and		

Facility ID: 00764

If continuation sheet Page 4 of 6

			(X2) MULTIPL	(X3) DATE SURVEY COMPLETED		
				01 - MAIN BUILDING 01		
		245569	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	08/08/2016	
NAME OF I	PROVIDER OR SUPPLIER					
HALSTAD LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K 050	Continued From pa	age 4	K 050			
	on 08/08/2016 rec revealed in the las missed on the 3rd	between 9:30 am to 12:30 pm ord review and staff interview t four quarters, a fire drill was shift in the 3rd quarter of 2015 ed on the 2nd shift in the 4th				
K 144 SS=F	Administrator and NFPA 101 LIFE SA Generators inspec	lition was verified by the Facility the Maintenance Engineer. AFETY CODE STANDARD ted weekly and exercised ninutes per month and shall be	K 144		8/9/16	
	in accordance with 3-4.4.1 and 8-4.2 (110) This STANDARD Based on review of the facility failed to generator in accor NFPA 110 - 1999 e could affect the sa	NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA is not met as evidenced by: of records and staff interview, monitor the emergency dance with the requirements of adition. This deficient practice fety of all 40 residents and an ount of staff and visitors.		The generator cool down cycle is now being logged on the current generator and will be done with every report. Findings will be reviewed with the QA committee quarterly to ensure compliance.		
	on 08/08/2016 rec revealed the gene being logged. This deficient cond	between 9:30 am to 12:30 pm ord review and staff interview rator cool down cycle was not dition was verified by the Facility the Maintenance Engineer.				

Facility ID: 00764

If continuation sheet Page 5 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245569 B. WING 08/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **133 FOURTH AVENUE EAST** HALSTAD LIVING CENTER HALSTAD, MN 56548 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 144 Continued From page 5 K 144 8/9/16 K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 SS=D Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: The non listed electrical adapter in the Based on observation and interview with the clean utility room 109 was removed. All staff, the facility was using an unapproved electrical device that is not in accordance with rooms were inspected for non listed electrical devices. Quarterly walk-throughs NFPA 70 (99), National Electrical Code. This will be conducted by Maintenance staff to deficient practice could negatively affect the ensure no further use of non listed safety of 4 of the 40 residents, and an undetermined amount of staff and visitors. electrical devices. This report will be reviewed by the QA and Safety Committees quarterly. Findings include: On the facility tour between 9:30 am to 12:30 pm on 08/08/2016 observations and staff interview revealed the use of a non listed electrical adapter being used a the clean utility room, 109. This deficient condition was verified by the Facility Administrator and the Maintenance Engineer.

Facility ID: 00764

If continuation sheet Page 6 of 6

PRINTED: 08/31/2016



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted August 19, 2016

Ms. Angela Nelson, Administrator Halstad Living Center 133 Fourth Avenue East Halstad, MN 56548

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5569027

Dear Ms. Nelson:

The above facility was surveyed on August 8, 2016 through August 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

Halstad Living Center August 19, 2016 Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman, Unit Supervisor at (218)308-2104.

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s) cc: Original - Facility Licensing and Certification File Halstad Living Center August 19, 2016 Page 3

PRINTED: 09/23/2016 FORM APPROVED

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY
		00764	B. WING		08/0	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HALSTA	D LIVING CENTER		RTH AVENUE 9, MN 56548	E EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depart	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess					
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 08/26/16

STATE FORM

If continuation sheet 1 of 45

PRINTED: 09/23/2016 FORM APPROVED

STATEMENT	a Department of He OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00764	B. WING		08/	08/04/2016	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
HALSTAD	LIVING CENTER		JRTH AVENUE D, MN 56548	EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure pro completion date, the corrected prior to e Minnesota Departm On 8/1-4/16, surver visited the above p correction orders a your electronic plar reviewed these ord they will be comple Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag m column entitled "IE statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are in after the statement evidence by." Follo are the Suggested Time period for Correction PLEASE DISREGA	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. yors of this Department's staff, rovider and the following re issued. Please indicate in n of correction that you have ers, and identify the date wher ted. nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the nis column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and		DEFICIENC	·Υ)		

KMB911
Minneso	ta Department of He	alth			FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY
		00764	B. WING		08/0	04/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HALSTA	D LIVING CENTER		RTH AVENU 0, MN 56548			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 510	MN Rule 4658.0300	0 Subp. 2 Use of Restraints	2 510			8/26/16
	must be free from a restraints imposed	from restraints. Residents any physical or chemical for purposes of discipline or not required to treat the symptoms.				
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview and document illed to ensure residents were estraint for 1 of 3 residents restraints.		Corrected.		
	Findings include:					
	7/18/16, identified F impaired and had d dementia, depressi MDS identified R22 staff for activities of a wheelchair for loc	imum Data Set (MDS) dated R22 was severely cognitively iagnoses which included on and reduced mobility. The required total assistance from daily living (ADL's) and used comotion. The MDS did not obysical restraint during the 7 priod.				
	revealed R22 had s and required total a ADL's. R22's care p space chair and rec locomotion to destin	rrent care plan dated 7/17/16, severe cognitive impairment issistance from facility staff for plan revealed R22 used a tilt in quired assistance with nations. R22's care plan				
innesota D	epartment of Health		6899			ion shoot 3 of

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00764	B. WING	3. WING		08/04/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
			JRTH AVENUE				
HALSTA	D LIVING CENTER		D, MN 56548				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETI DATE	
2 510	Continued From pa	ge 3	2 510				
	lacked documentation to lock her wheelchair brakes.						
	Review of R22's me restraint assessme	edical record revealed no nts.					
		ogress notes form 2/4/16, to o documentation on use of a t for R22.					
	7:01 a.m. to 8:14 a. seated in a tilt in sp to have her eyes op R22's right wheelch a.m. R22 remained wheelchair with her wheelchair brake lo the floor and her lef foot rest. At 7:28 a. the tilt in space cha her eyes open. R22 footrest of the wheelchair. R22 wheelchair with her move forward as th locked. R22 placed began to repeated The director of nurs	s continuously observed from m. At 7:01 a.m. R22 was ace chair. R22 was observed ben and was looking around. hair brake was locked. At 7:22 seated in the tilt in space eyes closed and her cked. R22's right foot was on it foot was on the wheelchair m. R22 remained seated in ir near the nurses station with 2 placed her right foot on the elchair, reached down with her bed hold of the right wheel of 2 attempted to propel her right arm and was unable to e wheelchair brake was both feet on the floor and y tap both feet on the floor. sing (DON) was observed to ed in the wheelchair, but did					
	not approach R22. registered nurse (R near R22 at the nur approach her or dis	Nursing assistant (NA)-A and N)-A were observed to walk ses station, but did not engage the wheelchair brake.					
	space chair, with th reached down with	mained seated in the tilt in e right brake engaged. R22 her right hand to the nd attempted to propel the					

Minneso	ta Department of He	ealth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:	·····		
		00764	B. WING		08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	D LIVING CENTER	133 FOU	RTH AVENUE	EAST		
HALSTA		HALSTA	D, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 510	Continued From pa	age 4	2 510			
	R22 in the wheelch provide assistance, behind R22, verbal she would move R2 RA-A reached down R22's right wheel a wheelchair to her re room, RA-A stated back into her tilt in R22 to lean forward blue slacks to pull h of the chair. RA-A t and assisted R22 in common area by th lock R22's wheelch	aid (RA)-A was observed near air at that time, and did not At 7:31 a.m. RA-A stood ized to the medication nurse 22 back in her wheelchair. In and released the brake on and assisted R22 in the bom. Upon entering R22's R22 needed to be scooted space chair. RA-A then asked d and used the back of R22's her buttocks towards the back hen adjusted R22's head rest in her wheelchair back to the ne nurses station. RA-A did not pair brake. R22 remained in the hair propelling herself around				
	practice to lock a b on how she had be was able to propel but at times could r wheelchair brakes a.m. R22 remained wheelchair and pro down the 300 wing R22 and stated it w NA-A turned R22's brought R22 back t nurses station whe residents wheelcha and engaged R22's immediately walked a.m. RN-A walked stood at R22's left the upcoming breat	a.m. RA-A stated it was usual rake on R22's chair depending en doing. RA-A stated R22 herself in the tilt in space chair not and that's when R22's were locked for safety. At 8:05 I seated in the tilt in space pelled her wheelchair 2 doors hallway. NA-A approached vas almost breakfast time. wheelchair around and to the common area by the re she stopped next to another tir. NA-A then reached down is left wheelchair brake and d away from the area. At 8:10 over to R22 in the wheelchair, side and spoke with her about kfast meal. RN-A proceeded to 2 had not disengaged R22's				
		2, had not disengaged R22's ke. At 8:13 a.m. licensed				
innesota D	epartment of Health		I			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		RTH AVENUE), MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 510	wheelchair and adr LPN-A attempted to forward, and was u with the brake enga brake and moved F NA-A took R22 to th her to the table. NA engaged R22's righ in her tilt in space v 8:14 a.m. to 8:54 a wheelchair brake re during the entire br On 8/3/16, at 8:16 a propel herself in the not recall unlocking LPN-A stated R22's be locked as she co stated R22 needed destinations, but co distance. At 8:54 a. disengaged her righ of the dining room in nurses station. NA- wheelchair brake. A R22 and offered an After R22 agreed, A common area into On 8/3/16, at 8:22 a able to propel her v times. RN-A stated wheelchair would b also stated R22 did for the use of a res	N)-A approached R22 in her ninistered medications to R22. o move R22's wheelchair nable to move the wheelchair aged. LPN-A disengaged the R22 toward the dining room. he dining room, and brought A-A reached down and nt brake. R22 remained seated wheelchair at the table from .m. to eat breakfast. R22's emained engaged/locked eakfast meal. a.m. LPN-A stated R22 could e tilt in space chair and could g R22's wheelchair brake. s wheelchair brakes should not ould "meander" around. LPN-A assistance to reach ould wheel herself a fair .m. NA-A approached R22, ht brake and assisted R22 out into the common area by the A did not engage/ lock R22's Activity aid (AA)-A approached nopportunity to fold towels. AA-A assisted R22 out of the the activity room. a.m. RN-A confirmed R22 was wheelchair independently at engaging the brakes on R22's e considered a restraint. RN-A I not have a physician's order traint. RN-A confirmed R22's id not direct staff to lock R22's				
	On 8/3/16, at 8:25 a	a.m. the director of nursing				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		IRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 510	(DON) confirmed F wheelchair and ind wheelchair brake w for R22. The DON to follow a resident expect staff not to I The DON also state was locking resider indicated she had o they were locking b this practice had be On 8/3/16, at 9:25 a routinely lock R22's away. NA-A stated before, but felt as a lock R22's brake. N herself in her whee go to a specific des impairment. NA-A s wheelchair brake w independently prop locked the brake ou A facility policy and Restraint, revised 5 a physical or mechar equipment which w freedom of movem The policy directed	R22 could propel herself in her icated locking either rould be considered a restraint stated she would expect staff s care plan and she would ock R22's wheelchair brakes. ed she was aware some staff nt wheelchair brakes. She questioned staff about why orakes and the DON believed ecome habit with some staff. a.m. NA-A stated she would s brake so R22 did not roll R22 had not rolled away a safety measure she would JA-A stated R22 could propel lichair but would not be able to stination due to cognitive stated locking R22's rould prevent her from relling herself. NA-A stated she				
	The director of nurs develop systems to restraints without a designee could edu	THOD FOR CORRECTION: sing (DON) or designee could ensure staff do not implemen n assessed need. The DON or ucate all appropriate staff. The could conduct audits to ensure				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
		00764	B. WING		08/04/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENU D, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
2 510	Continued From pa	ige 7	2 510			
	ongoing compliance to the QA committe	e and report the audit results e.				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21))			
2 520	MN Rule 4658.030	0 Subp. 3 B Use of Restraints	2 520		8/26/16	
	Subp. 3. Emergen	cy use of restraint.				
	must be obtained w	needed, a physician's order hich specifies the duration under which the restraint is to				
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview and document ailed to ensure residents were restraint for 1 of 3 residents restraints.		Corrected.		
	Findings include:					
	7/18/16, identified F impaired and had d dementia, depressi MDS identified R22 staff for activities of a wheelchair for loc	imum Data Set (MDS) dated R22 was severely cognitively liagnoses which included on and reduced mobility. The required total assistance from daily living (ADL's) and used comotion. The MDS did not ohysical restraint during the 7 eriod.				
	revealed R22 had s and required total a	rrent care plan dated 7/17/16, severe cognitive impairment issistance from facility staff for plan revealed R22 used a tilt in				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/04/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 520	Continued From pa	age 8	2 520			
	space chair and required assistance with locomotion to destinations. R22's care plan lacked documentation to lock her wheelchair brakes.					
	Review of R22's medical record revealed no restraint assessments.					
		ogress notes form 2/4/16, to to documentation on use of a t for R22.				
	7:01 a.m. to 8:14 a seated in a tilt in sp to have her eyes of R22's right wheelch a.m. R22 remained wheelchair with her wheelchair brake lo the floor and her le foot rest. At 7:28 a. the tilt in space cha her eyes open. R22 footrest of the wheel right arm and grabt the wheelchair. R22 wheelchair with her move forward as the locked. R22 placed began to repeated The director of nursi walk past R22 seat	s continuously observed from .m. At 7:01 a.m. R22 was bace chair. R22 was observed ben and was looking around. hair brake was locked. At 7:22 I seated in the tilt in space r eyes closed and her bocked. R22's right foot was on ft foot was on the wheelchair m. R22 remained seated in hir near the nurses station with 2 placed her right foot on the elchair, reached down with her bod hold of the right wheel of 2 attempted to propel her r right arm and was unable to he wheelchair brake was I both feet on the floor and ly tap both feet on the floor. sing (DON) was observed to red in the wheelchair, but did Nursing assistant (NA)-A and				
	registered nurse (F near R22 at the nur approach her or dis At 7:30 a.m. R22 re	RN)-A were observed to walk rses station, but did not sengage the wheelchair brake. emained seated in the tilt in he right brake engaged. R22				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/04/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
			JRTH AVENUE			
IALSTA	D LIVING CENTER		D, MN 56548			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE
				DEFICIENC	CY)	
2 520	Continued From pa	age 9	2 520			
		-				
		Ind attempted to propel the . R22 was unable to move her				
		aid (RA)-A was observed near				
		air at that time, and did not				
		. At 7:31 a.m. RA-A stood				
		ized to the medication nurse				
	,	22 back in her wheelchair.				
		n and released the brake on				
		and assisted R22 in the				
		bom. Upon entering R22's				
		R22 needed to be scooted				
		space chair. RA-A then asked				
		d and used the back of R22's				
		her buttocks towards the back				
		hen adjusted R22's head rest				
		n her wheelchair back to the				
		ne nurses station. RA-A did not				
		air brake. R22 remained in the				
		hair propelling herself around	·			
	the common area.					
	On 8/3/16, at 7:36 a	a.m. RA-A stated it was usual				
		rake on R22's chair depending				
	on how she had be	en doing. RA-A stated R22				
		herself in the tilt in space chair				
	but at times could r	not and that's when R22's				
	wheelchair brakes	were locked for safety. At 8:05				
	a.m. R22 remained	I seated in the tilt in space				
	wheelchair and pro	pelled her wheelchair 2 doors				
		hallway. NA-A approached				
		as almost breakfast time.				
	NA-A turned R22's	wheelchair around and				
		to the common area by the				
		re she stopped next to another	· I I			
		air. NA-A then reached down				
		s left wheelchair brake and				
		d away from the area. At 8:10				
		over to R22 in the wheelchair,				
		side and spoke with her about				
	the uncoming break	kfast meal. RN-A proceeded to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	<u>.</u>	
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 520	walk away from R2 left wheelchair brak practical nurse (LP) wheelchair and adr LPN-A attempted to forward, and was u with the brake enga brake and moved F NA-A took R22 to th her to the table. NA engaged R22's righ in her tilt in space v 8:14 a.m. to 8:54 a. wheelchair brake re during the entire br On 8/3/16, at 8:16 a propel herself in the not recall unlocking LPN-A stated R22's be locked as she co stated R22 needed destinations, but co distance. At 8:54 a. disengaged her righ of the dining room in nurses station. NA- wheelchair brake. A R22 and offered an After R22 agreed, A common area into the On 8/3/16, at 8:22 a able to propel her v times. RN-A stated wheelchair would b also stated R22 did	 2, had not disengaged R22's 2, had not disengaged R22's 3, A approached R22 in her ninistered medications to R22. p move R22's wheelchair nable to move the wheelchair aged. LPN-A disengaged the R22 toward the dining room. ne dining room, and brought A reached down and th brake. R22 remained seated wheelchair at the table from m. to eat breakfast. R22's emained engaged/locked eakfast meal. a.m. LPN-A stated R22 could e tilt in space chair and could R22's wheelchair brake. s wheelchair brakes should not pould "meander" around. LPN-A assistance to reach puld wheel herself a fair m. NA-A approached R22, nt brake and assisted R22 out nto the common area by the A did not engage/ lock R22's Activity aid (AA)-A approached opportunity to fold towels. AA-A assisted R22 out of the 	2 520			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00764	B. WING		08/04/2016		
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
IALSTA	D LIVING CENTER		IRTH AVENUE D, MN 56548	EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 520	Continued From pa	age 11	2 520				
	(DON) confirmed F wheelchair and ind wheelchair brake w for R22. The DON to follow a resident expect staff not to I The DON also state was locking resider indicated she had of they were locking b this practice had be On 8/3/16, at 9:25 a routinely lock R22's away. NA-A stated before, but felt as a lock R22's brake. N herself in her whee go to a specific des impairment. NA-A s wheelchair brake w independently prop locked the brake on A facility policy and	procedure titled, Physical					
	a physical restraint physical or mechar equipment which w freedom of movem The policy directed	5/09, identified the definition of was any manual method or nical device, material or rould restrict an individuals ent or access to ones body. staff physical restraints were en ordered or in a medical					
	director of nursing develop systems to	THOD OF CORRECTION: The (DON) or designee could o ensure staff obtain a rhen a restraint is assessed to					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		00764	B. WING		08/04/2016	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS. CITY.	STATE, ZIP CODE		04/2010
	D LIVING CENTER	133 FOL	JRTH AVENU	EEAST		
	1		D, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 520	Continued From pa	ige 12	2 520			
	educate all appropri designee could con compliance and rep committee. TIME PERIOD FOR	DON or designee could riate staff. The DON or induct audits to ensure ongoing port the audit results to the QA R CORRECTION: Twenty (21)				
2 530	days MN Rule 4658.030	0 Subp. 4 Use of Restraints	2 530			8/26/16
	decision to apply a comprehensive res restrictive restraint incorporated into the The comprehensive progressive remova- less restrictive mea obtain an informed in a physical or che order must be obta restraint which spee circumstances und used, including the in this part requires during the resident' strictly for the purpor This MN Requirements by:	e comprehensive plan of care e plan of care must allow for al or the progressive use of ans. A nursing home must consent for a resident placed mical restraint. A physician's ined for a physical or chemical cifies the duration and er which the restraint is to be monitoring interval. Nothing a resident to be awakened s normal sleeping hours ose of releasing restraints. ent is not met as evidenced				
	review the facility fa	ion, interview and document ailed to ensure residents were restraint for 1 of 3 residents restraints.		Corrected.		
	-	imum Data Sat (MDS) datad				
	nzzs quarteriy Min	iimum Data Set (MDS) dated				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED		
		00764	B. WING		08/	08/04/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE					
			JRTH AVENUE					
HALSIA	D LIVING CENTER	HALSTA	D, MN 56548					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 530	Continued From pa	ige 13	2 530					
	impaired and had d dementia, depressi MDS identified R22 staff for activities of a wheelchair for loc identify R22 had a day assessment per Review of R22's cur revealed R22 had s and required total a ADL's. R22's care p space chair and rec locomotion to destin	R22 was severely cognitively liagnoses which included on and reduced mobility. The Prequired total assistance from f daily living (ADL's) and used comotion. The MDS did not physical restraint during the 7 eriod. Internet care plan dated 7/17/16, severe cognitive impairment assistance from facility staff for plan revealed R22 used a tilt in quired assistance with nations. R22's care plan ion to lock her wheelchair						
	Review of R22's me restraint assessme	edical record revealed no nts.						
		ogress notes form 2/4/16, to to documentation on use of a t for R22.						
	7:01 a.m. to 8:14 a. seated in a tilt in sp to have her eyes op R22's right wheelch a.m. R22 remained wheelchair with her wheelchair brake lo the floor and her let foot rest. At 7:28 a. the tilt in space cha her eyes open. R22 footrest of the wheel	s continuously observed from .m. At 7:01 a.m. R22 was pace chair. R22 was observed ben and was looking around. hair brake was locked. At 7:22 I seated in the tilt in space reyes closed and her ocked. R22's right foot was on ft foot was on the wheelchair m. R22 remained seated in hir near the nurses station with 2 placed her right foot on the elchair, reached down with her bed hold of the right wheel of						

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 530	wheelchair with her move forward as the locked. R22 placed began to repeated The director of nurse walk past R22 seat not approach R22. registered nurse (Finear R22 at the nur approach her or dis At 7:30 a.m. R22 respace chair, with the reached down with wheelchair wheel at wheelchair forward wheelchair forward wheelchair. Rehab R22 in the wheelch provide assistance behind R22, verbal she would move R2 RA-A reached dow R22's right wheel at wheelchair to her re room, RA-A stated back into her tilt in R22 to lean forward blue slacks to pull of the chair. RA-A ta and assisted R22 in common area by the lock R22's wheelch tilt in space wheelch the common area. On 8/3/16, at 7:36 practice to lock a b on how she had be was able to propel but at times could response.	age 14 r right arm and was unable to he wheelchair brake was d both feet on the floor and lly tap both feet on the floor. sing (DON) was observed to ted in the wheelchair, but did Nursing assistant (NA)-A and RN)-A were observed to walk rses station, but did not sengage the wheelchair brake. emained seated in the tilt in he right brake engaged. R22 her right hand to the and attempted to propel the l. R22 was unable to move her aid (RA)-A was observed near hair at that time, and did not . At 7:31 a.m. RA-A stood lized to the medication nurse 22 back in her wheelchair. In and released the brake on and assisted R22 in the oom. Upon entering R22's R22 needed to be scooted space chair. RA-A then asked d and used the back of R22's her buttocks towards the back then adjusted R22's head rest in her wheelchair back to the ne nurses station. RA-A did not hair propelling herself around a.m. RA-A stated it was usual rake on R22's chair depending ben doing. RA-A stated R22 herself in the tilt in space chair not and that's when R22's were locked for safety. At 8:05				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
HALSTA	D LIVING CENTER		RTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 530	Continued From pa	ge 15	2 530			
	wheelchair and pro down the 300 wing R22 and stated it w NA-A turned R22's brought R22 back t nurses station wheel residents wheelchai and engaged R22's immediately walked a.m. RN-A walked of stood at R22's left s the upcoming breat walk away from R2 left wheelchair brak practical nurse (LPI wheelchair and adr LPN-A attempted to forward, and was u with the brake enga- brake and moved F NA-A took R22 to th her to the table. NA- engaged R22's righ in her tilt in space w 8:14 a.m. to 8:54 a. wheelchair brake re- during the entire br On 8/3/16, at 8:16 a propel herself in the not recall unlocking LPN-A stated R22's be locked as she co stated R22 needed destinations, but co distance. At 8:54 a. disengaged her righ of the dining room in	seated in the tilt in space pelled her wheelchair 2 doors hallway. NA-A approached as almost breakfast time. wheelchair around and o the common area by the re she stopped next to another ir. NA-A then reached down a left wheelchair brake and d away from the area. At 8:10 over to R22 in the wheelchair, side and spoke with her about kfast meal. RN-A proceeded to 2, had not disengaged R22's te. At 8:13 a.m. licensed N)-A approached R22 in her ninistered medications to R22. o move R22's wheelchair nable to move the wheelchair aged. LPN-A disengaged the R22 toward the dining room. ne dining room, and brought the ached down and the brake. R22 remained seated wheelchair at the table from .m. to eat breakfast. R22's emained engaged/locked eakfast meal. a.m. LPN-A stated R22 could a tilt in space chair and could a R22's wheelchair brake. s wheelchair brakes should not ould "meander" around. LPN-A assistance to reach ould wheel herself a fair m. NA-A approached R22, nt brake and assisted R22 out nto the common area by the A did not engage/ lock R22's				

(EACH DEFICIENC) REGULATORY OR L Continued From pa wheelchair brake. A R22 and offered an	133 FOU HALSTAI	B. WING DORESS, CITY, ST RTH AVENUE D, MN 56548 ID PREFIX TAG		ION LD BE	04/2016
LIVING CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa wheelchair brake. A R22 and offered an	133 FOU HALSTAI	RTH AVENUE D, MN 56548	EAST PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa wheelchair brake. A R22 and offered an	HALSTAI	D, MN 56548	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	
(EACH DEFICIENC) REGULATORY OR L Continued From pa wheelchair brake. A R22 and offered an	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 16	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	
wheelchair brake. A R22 and offered an	-		DEFICIENCY		DATE
R22 and offered an	Λ at i i the end $(\Lambda\Lambda)$ Λ are an end of Λ	2 530			
After R22 agreed, A common area into t	opportunity to fold towels. AA-A assisted R22 out of the				
able to propel her w imes. RN-A stated wheelchair would b also stated R22 did or the use of a rest	vheelchair independently at engaging the brakes on R22's e considered a restraint. RN-A I not have a physician's order traint. RN-A confirmed R22's id not direct staff to lock R22's				
DON) confirmed R wheelchair and indi wheelchair brake w or R22. The DON s o follow a residents expect staff not to b The DON also state was locking resider ndicated she had c hey were locking b	A22 could propel herself in her icated locking either rould be considered a restraint stated she would expect staff s care plan and she would ock R22's wheelchair brakes. ed she was aware some staff nt wheelchair brakes. She questioned staff about why orakes and the DON believed				
outinely lock R22's away. NA-A stated before, but felt as a ock R22's brake. N herself in her whee go to a specific des mpairment. NA-A s wheelchair brake w ndependently prop	s brake so R22 did not roll R22 had not rolled away a safety measure she would IA-A stated R22 could propel Ichair but would not be able to stated locking R22's rould prevent her from elling herself. NA-A stated she				
AINACON CINNCONTRACTOR OCTORNO	ble to propel her v mes. RN-A stated vheelchair would b lso stated R22 did or the use of a res urrent care plan d vheelchair brakes. On 8/3/16, at 8:25 a DON) confirmed F vheelchair and indiv vheelchair brake w or R22. The DON o follow a resident xpect staff not to I vhe DON also stated vas locking resident vas locking res	wheelchair would be considered a restraint. RN-A lso stated R22 did not have a physician's order or the use of a restraint. RN-A confirmed R22's urrent care plan did not direct staff to lock R22's wheelchair brakes. On 8/3/16, at 8:25 a.m. the director of nursing DON) confirmed R22 could propel herself in her wheelchair and indicated locking either wheelchair brake would be considered a restraint or R22. The DON stated she would expect staff of follow a residents care plan and she would expect staff not to lock R22's wheelchair brakes. The DON also stated she was aware some staff vas locking resident wheelchair brakes. She ndicated she had questioned staff about why ney were locking brakes and the DON believed his practice had become habit with some staff. On 8/3/16, at 9:25 a.m. NA-A stated she would putinely lock R22's brake so R22 did not roll way. NA-A stated R22 had not rolled away efore, but felt as a safety measure she would pock R22's brake. NA-A stated R22 could propel erself in her wheelchair but would not be able to o to a specific destination due to cognitive mpairment. NA-A stated locking R22's wheelchair brake would prevent her from ndependently propelling herself. NA-A stated she bocked the brake out of habit.	ble to propel her wheelchair independently at mes. RN-A stated engaging the brakes on R22's wheelchair would be considered a restraint. RN-A lso stated R22 did not have a physician's order or the use of a restraint. RN-A confirmed R22's urrent care plan did not direct staff to lock R22's wheelchair brakes. On 8/3/16, at 8:25 a.m. the director of nursing DON) confirmed R22 could propel herself in her wheelchair and indicated locking either wheelchair brake would be considered a restraint or R22. The DON stated she would expect staff o follow a residents care plan and she would xpect staff not to lock R22's wheelchair brakes. Whe DON also stated she was aware some staff vas locking resident wheelchair brakes. She ndicated she had questioned staff about why ney were locking brakes and the DON believed his practice had become habit with some staff. On 8/3/16, at 9:25 a.m. NA-A stated she would putinely lock R22's brake so R22 did not roll way. NA-A stated R22 had not rolled away efore, but felt as a safety measure she would pok R22's brake. NA-A stated R22 could propel erself in her wheelchair but would not be able to o to a specific destination due to cognitive npairment. NA-A stated locking R22's wheelchair brake would prevent her from idependently propelling herself. NA-A stated she bocked the brake out of habit.	ble to propel her wheelchair independently at mes. RN-A stated engaging the brakes on R22's /heelchair would be considered a restraint. RN-A lso stated R22 did not have a physician's order or the use of a restraint. RN-A confirmed R22's urrent care plan did not direct staff to lock R22's /heelchair brakes. Dn 8/3/16, at 8:25 a.m. the director of nursing DON) confirmed R22 could propel herself in her /heelchair and indicated locking either /heelchair brake would be considered a restraint or R22. The DON stated she would expect staff o follow a residents care plan and she would xpect staff not to lock R22's wheelchair brakes. he DON also stated she was aware some staff ras locking resident wheelchair brakes. She dicated she had questioned staff about why yeey were locking brakes and the DON believed his practice had become habit with some staff. Dn 8/3/16, at 9:25 a.m. NA-A stated she would butinely lock R22's brake so R22 did not roll way. NA-A stated R22 had not rolled away efore, but felt as a safety measure she would bok R22's brake. NA-A stated R22 could propel erself in her wheelchair but would not be able to o to a specific destination due to cognitive npairment. NA-A stated locking R22's /heelchair brake would prevent her from idependently propelling herself. NA-A stated she pocked the brake out of habit. .facility policy and procedure titled, Physical	ble to propel her wheelchair independently at mes. RN-A stated engaging the brakes on R22's heelchair would be considered a restraint. RN-A lso stated R22 did not have a physician's order or the use of a restraint. RN-A confirmed R22's urrent care plan did not direct staff to lock R22's heelchair brakes. On 8/3/16, at 8:25 a.m. the director of nursing DON) confirmed R22 could propel herself in her heelchair brake would be considered a restraint or R22. The DON stated she would expect staff to follow a residents care plan and she would xpect staff not to lock R22's wheelchair brakes. he DON also stated she would expect staff to follow a residents care plan and she would xpect staff not to lock R22's wheelchair brakes. he DON also stated she was aware some staff ras locking resident wheelchair brakes. She dicated she had questioned staff about why rey were locking brakes and the DON believed his practice had become habit with some staff. On 8/3/16, at 9:25 a.m. NA-A stated she would pottinely lock R22's brake so R22 did not roll way. NA-A stated R22 had not rolled away efore, but felt as a safety measure she would pock R22's brake. NA-A stated R22 could propel erself in her wheelchair but would not be able to o to a specific destination due to cognitive mpairment. NA-A stated locking R22's heelchair brake would prevent her from independently propelling herself. NA-A stated she pocked the brake out of habit.

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 530	Continued From pa	age 17	2 530			
	a physical restraint physical or mechar equipment which w freedom of movem The policy directed	5/09, identified the definition of was any manual method or nical device, material or rould restrict an individuals ent or access to ones body. staff physical restraints were en ordered or in a medical				
	director of nursing develop systems to comprehensive ass restraint is necessa could educate all a designee could cor	THOD OF CORRECTION: The (DON) or designee could o ensure staff complete a sessment to determine if a ary. The DON or designee ppropriate staff. The DON or nduct audits to ensure ongoing port the audit results to the QA				
	TIME PERIOD FOI days	R CORRECTION: Twenty (21))			
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			8/26/16
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the cor assessment. The of must include the in	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by:	ent is not met as evidenced		Corrotted		
	Daseu un observat	ion, interview and document		Corrected.		

STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		RTH AVENUE), MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 560	Continued From pa	age 18	2 560			
	review the facility fa for 1 of 1 residents catheter.	ailed to revise the plan of care (R31) reviewed with a				
	Findings include:					
	5/23/16, identified l impairment, require activities of daily liv lower extremetity ir	nimum Data Set (MDS) dated R31 had moderate cognitive ed extensive assistance with all ring (ADLs) and had upper and mpairment. The MDS also always incontinent of bowel				
	an indwelling cathe inability to void for was to monitor for Foley catheter mor weeks. Although fa and identified multi attempt, the care p	ted 7/7/16, identified R31 had eter placed 7/5/16, for an extended periods of time. Staff odorous urine, change the hthly and the Foley bag every 2 acility staff was aware of odor ple interventions they could lan failed to identify additional minimizing the urine odor for				
	in his room in front bag contained in a	p.m. R31 was in his wheelchair of the TV. R31 had a catheter cloth bag on the side of his bedroom had a strong, foul, odor.				
	asleep with the cat cloth bag which sa small silver pitcher and empty urinal w R31's bedroom and	a.m. R31 was observed in bed heter collection bag inside a t on the floor next to his bed. A to measure urine output and rere on the back of R31's toilet. d bathroom continued to have centrated urine odor.				
		a.m. registered nurse (RN-B)				
ATE FORI	epartment of Health M		⁶⁸⁹⁹ KI	MB911	If continuation	on sheet 19 o

1				
00764	B. WING		08/	04/2016
STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	-	EAST		
TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
causing the urine odor. She was "a little thicker" because d liquids. RN-B stated R31 fluids which contributed to oblem. She stated there were ave tried to limit R31's urine ing with vinegar, or changing γ . She stated the catheter is nd the bag twice per month. rsing assistant's (NA's) wash with soap and water twice a as needed if they noticed hursing was responsible for quipment. She confirmed the hanged the catheter bag was a.m. trained medication stated R31's urine in the bag is started with the initiation of the d when she noticed the odor ave to change it. TMA-B low if she told the nurse about oday. She stated all catheters tated she washed R31's coap and water, emptied R31's rmed she didn't rinse out the tack up. a.m. during a follow-up	5	DEFICIENC	Y)	
	STREET AI 133 FOL HALSTAI TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 19 are of R31's urine odor and or started soon after R31's d. She stated she felt there e tube that could be causing theter should be gone through causing the urine odor. She was "a little thicker" because d liquids. RN-B stated R31 fluids which contributed to oblem. She stated there were ave tried to limit R31's urine ing with vinegar, or changing /. She stated the catheter is nd the bag twice per month. rsing assistant's (NA's) wash with soap and water twice a as needed if they noticed hursing was responsible for quipment. She confirmed the anged the catheter bag was a.m. trained medication stated R31's urine in the bag is tarted with the initiation of the d when she noticed the odor ave to change it. TMA-B ow if she told the nurse about oday. She stated all catheters tated she washed R31's coap and water, emptied R31's rmed she didn't rinse out the tack up. a.m. during a follow-up ed NA's open the catheter	STREET ADDRESS, CITY, ST 133 FOURTH AVENUE HALSTAD, MN 56548 TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ge 19 are of R31's urine odor and or started soon after R31's d. She stated she felt there a tube that could be causing theter should be gone through causing the urine odor. She was "a little thicker" because d liquids. RN-B stated R31 fluids which contributed to oblem. She stated there were ave tried to limit R31's urine ing with vinegar, or changing A. She stated the catheter is and the bag twice per month. rsing assistant's (NA's) wash with soap and water twice a as needed if they noticed nursing was responsible for quipment. She confirmed the anged the catheter bag was a.m. trained medication stated R31's urine in the bag is tarted with the initiation of the d when she noticed the odor ave to change it. TMA-B ow if she told the nurse about oday. She stated all catheters toap	STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST HALSTAD, MN 56548 TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 19 2 560 are of R31's urine odor and or started soon after R31's d. She stated she felt there a tube that could be causing theter should be gone through causing the urine odor. She was "a little thicker" because d liquids. RN-B stated R31 fluids which contributed to oblem. She stated there were ave tried to limit R31's urine ing with vinegar, or changing /. She stated the catheter is nd the bag twice per month. rsing assistant's (NA's) wash with soap and water twice a as needed if they noticed nursing was responsible for quipment. She confirmed the anged the catheter bag was a.m. trained medication stated R31's urine in the bag is tarted with the initiation of the d when she noticed the odor ave to change it. TMA-B ow if she told the nurse about oday. She stated all catheters tated she washed R31's toop and water, emptied R31's toop and water, emptied R31's toop and water, emptied R31's	STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST HALSTAD, MN 56548 TEMENT OF DEFICIENCIES NUSST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 19 2 560 PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG P

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00764	B. WING		08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
HALSTA	D LIVING CENTER		IRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	responsible for irrig evening or night sh know where the od stated the odor hun She stated when sh day it was really ba changed his cathet talked to the night r her to irrigate the tu stated she felt it he On 8/3/16, at 11:48 R31's urine odor to She stated she was soap and water and She confirmed she emptied it. On 8/3/16, at 12:25 urine odor in R31's confirmed the urine from the pitcher and toilet which were us R31's catheter bag from the cloth bag of cc of light brown ur urine odor was from stated she felt R31' there were no "chun don't rinse the bag have caused more have rinsed the bag bag, and rinsed the used 2 different bag control drops or effic control R31's urine On 8/3/16, at 1:10 p	ating with vinegar during the ift. RN-B stated she didn't or was coming from and ng in the bag and in the tubing. he noticed the odor the other d and she should have er at that time. She stated she nurse the other night and had ubing with plain water and lped. a.m. NA-D stated she noticed day and she told the nurse. shed R31's perineal area with d emptied the catheter bag. didn't rinse the bag after she bedroom and bathroom. RN e odor in the bathroom was d urinal on the back of R31's sed to measure urine from . RN lifted R31's catheter bag on the floor that contained 120 ine and confirmed the strong n R31's catheter bag. She 's urine looked pretty good as nks in it". She stated the NA's after emptying which would odor. She stated they could g after emptying, used a leg b bag every day with vinegar, gs alternating, or try odor erdent tablets in the bag to odor.		DEFICIENCY		
noceto D	(DON) stated she v	vould expect staff to follow the 31 to be free of urine odor. She	,			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 21	2 560			
	stated she was not odor until today.	aware that R31 had urine				
	Planning, revised 4 the facility to develor residents which wo	blicy and procedure titled, Care /04, revealed it was a policy of op individualized care plans for uld address assessed needs n place based upon	f			
	The director of nurs develop systems to individualized resid designee could edu DON or designee o system to ensure o	THOD FOR CORRECTION: sing (DON) or designee could ensure timely revisions to the ent plans of care. The DON or ucate all appropriate staff. The could develop an auditing ingoing compliance and report uality assurance committee.	•			
	TIME PERIOD FOI days.	R CORRECTION: Twenty (21)			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			8/26/16
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observat review the facility fa planned interventio	ent is not met as evidenced ion, interview and document ailed to implement care ns for 2 of 3 residents (R22, repositioning and urinary		Corrected.		

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764			08/	04/2016
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			04/2010
IALSTA	D LIVING CENTER		RTH AVENUE), MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From pa	age 22	2 565			
	Findings include:					
	7/18/16, identified I impaired and had o dementia, depressi MDS identified R22 staff for activities o further identified R2 ulcer development, devices for chair an Review of R22's cu identified R22 was development due to incontinence. R22's pressure ulcer intel pressure air relieving directed facility staff reposition at least of with 2 staff assistant care plan revised 7 assist R22 with toil and to check R22's hours for total bow	himum Data Set (MDS) dated R22 was severely cognitively diagnoses which included ion and reduced mobility. The 2 required total assistance from f daily living (ADL's). The MDS 22 was at risk for pressure , required pressure reduction nd mattress surfaces. urrent care plan dated 7/17/16, at high risk for pressure ulcer o impaired mobility and s care plan identified current rventions in place included a ng mattress to R22's bed and a pad to recliner. R22's care plan ff to assist R22 to turn and every 2 hours and as needed nce. Review of R22's current 7/24/16, directed facilty staff to eting at least every 2 hours is incontinent brief every 2 el and bladder incontinence.				
	6:45 a.m. to 9:20 a minutes. On 8/3/16 observations 7:01 a observed to be rep checked/changed. in her tilt in space w through 9:20 a.m. v	ted in the same position from .m., a total of 2 hours and 35 6, during continuous a.m. 9:20 a.m. R22 was not positioned or R22 was observed to remain wheelchair from 7:01 a.m. without offloading from her rovision of toileting services.				
		a.m. NA-A stated R22 had last at 6:45 a.m. when the night				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
HALSTA	D LIVING CENTER		RTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	shift helped her get R22 was supposed checked and chang because of skin bre needed total assist toileting needs. On 8/3/16, at 9:29 a total assistance with and changing at lea On 8/3/16, at 10:40 interview NA-A stat hospice aide had as he was there for ca when R22's hospice responsible for repo changing R22 and done so. On 8/3/16, at 10:51 hospice NA note re to R22 by the hospic required assistance and changing at lea confirmed R22's ca directed staff to ass repositioning and to On 8/3/16, at 10:59	a.m. NA-C stated R22 required h repositioning and R22 ance with repositioning and checking ast every 2 hours. a.m. NA-C stated R22 required h repositioning and checking ast every 2 hours. a.m. during a follow up ed she had though R22's ssisted R22 to reposition when res that morning. NA-A stated e aide would come he was ositioning and checking and was not aware he had not a.m. RN-A confirmed the vealed no cares were provided ice aid. RN-A stated R22 e with repositioning, checking ast every 2 hours. RN-A ire plan was current and sist R22 with assessed				
	hours. Review of facility po Planning, revised 4 the facilty to develo	changing at least every 2 blicy and procedure titled, Care /04, revealed it was a policy of p individualized care plans for uld address assessed needs				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	1	
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From pa	age 24	2 565			
	assessment.					
	5/23/16, identified bowel and bladder	nimum Data Set (MDS) dated R31 was always incontinent of and was at risk for developing d had a pressure relieving				
	the potential for alt to impaired physica integrity, incontiner and multiple medic also identified R31	ted 7/7/15, identified R31 had eration in skin integrity related al mobility, impaired skin nce, poor safety awareness cal problems. The care plan required extensive assist of 2 position in bed and chair every cessary.				
	12/7/15, identified pressure ulcers as assistance with AD	sessment (CAA) dated R31 was at risk for developing R31 required extensive DLs, was always incontinent of and had weight loss.				
	Kardex Report whi assistant care guid	y form titled Visual/Bedside ch served as a nursing le, directed staff to turn and rry two hours when in bed and				
	to 8:00 p.m. identif or repositioned in h p.m. R31 was seat room table waiting Resident's chair wa 5:47 p.m. licensed administered R31's was fed his meal b	vation on 8/2/16, from 5:21 p.m ied R31 had not been offered his chair. On 8/2/16, at 5:21 ted in the dining room at dining for his evening meal. as in an upright position. At practical nurse (LPN)-B s medication. At 6:00 p.m. R31 by nursing assistant (NA)-H. At ed R31's wheelchair back				

	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	the day area. At 7: shirt down over his exposed. NA-G sta we'll have to put hir check with my part R31's head was ha off of the head rest intervention, R31 w On 8/2/16, at 7:56 p assigned to R31's of stated she didn't kr repositioned, but st supper. NA-G state repositioned every bed. She confirmed repositioning. On 8/3/16, at 8:26 c confirmed R31's ca have been reposition confirmed the reas repositioning was to skin breakdown. Sl extensive to total a repositioning. RN-E able to offload pres his chair without sta On 8/3/16, at 10:54 assistant (TMA)-B keep R31's skin int every 2 hours and bottom. She stated every 2 hours. She dependent on staff repositioning. She s	15 p.m. NA-G pulled R31's belly as his lower belly was ted out loud to herself, "I think m to bed soon, I'll have to ner and see what she says." unging forward and to the left, At 8:00 p.m., after surveyor vas laid down. p.m. NA-G stated she was was care for that evening. She now exactly when R31 was last tated it was sometime before ed R31 was supposed to be 2 hours when in his chair or d she did not offer R31 a.m. registered nurse (RN)-B are plan and stated R31 should oned every 2 hours. She on for every 2 hour o offload pressure and prevent he confirmed R31 required ssistance from staff for 3 confirmed R31 would not be ssure from his bottom while in				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00764	B. WING		08/	04/2016
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ige 26	2 565			
	plan directed them hours to prevent op	to reposition him every 2 pen areas.				
	(DON) stated R31 pressure ulcers and 2 hours. The DON extensive assistant totally dependent of stated she would e care and reposition the development of Review of facility pe Positioning, revised facility's procedure repositioning needs care plan based on	blicy and procedure titled, 3/09, revealed it was the to evaluate resident s, develop an individualized assessed need to prevent omote circulation and provide				
	The director of nurs develop systems to individualized resid designee could edu DON or designee o system to ensure o	THOD FOR CORRECTION: sing (DON) or designee could ensure implementation of the ent plans of care. The DON or ucate all appropriate staff. The could develop an auditing ngoing compliance and report uality assurance committee.				
	TIME PERIOD FOI days.	R CORRECTION: Twenty (21)				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			8/26/16
	comprehensive res	sores. Based on the ident assessment, the director must coordinate the				

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 133 FOURTH AVENUE EAST HALSTAD LIVING CENTER 133 FOURTH AVENUE EAST HALSTAD, MN 56548 (PAI) D PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTION SIGULD BE DEFICIENCY ON SIGULD BE RECULATORY OF LSC DENTIFYING INFORMATION) PREFX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SIGULD BE DEFICIENCY) ON (EACH CORRECTIVE ACTION SIGULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ON DEFICIENCY) 2 900 Continued From page 27 development of a nursing care plan which provides that: 2 900 2 900 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and 2 900 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Corrected. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement every two hour repositioning for 1 of 3 residents (R2) at risk for and with a history of pressure ulcer development who required staff assistance with repositioning. Corrected. Findings include: R22's quarterly Minimum Data Set (MDS) dated 7/18/16, identified R22 was serverely cognitively impaired and had diagnoses which included, dementia, depression and reduced mobility. The MDS identified R22 required total assistance from staff tor activities of daily living (ADL's). The MDS further identified R2			00764	B. WING		08/04	4/2016
HALSTAD_LIVING CENTER HALSTAD, MN 56548 (24) ID PREEK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PIE/ PRECEDUATION CONSCRETE ACTION SPOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Or CONSCRETE ACTION SPOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 900 Continued From page 27 development of a nursing care plan which provides that: 2 900 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and S. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Corrected. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement every two hour repositioning for 1 of 3 residents (R22) at risk for and with a history of pressure ulcers and 1 of 3 residents (R31) at risk for pressure ulcer development who required staff assistance with repositioning. Corrected. Findings include: R22's quarterly Minimum Data Set (MDS) dated 7/18/16, identified R22 was serverely cognitively impaired and had diagnoses which included, dementia, depression and reduced mobility. The MDS identified R22 required total assistance from staff tor activities of daily living (ADL's). The MDS further identified R22 was at risk for pressure ulcer development, required pressure reduction	NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MAID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EXCH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OF LGC IDENTFYING INFORMATION) ID PREFIX TAG PROVIDES FLAM OF CORRECTION (EXCH DEFICIENCY) OD OD DEFICIENCY 2 900 Continued From page 27 development of a nursing care plan which provides that: 2 900 2 900 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and 2 900 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Corrected. This MN Requirement is not met as evidenced by: nesident (R31) at risk for pressure ulcer development who required staff assistance with repositioning. Corrected. Findings include: R22's quarterly Minimum Data Set (MDS) dated d7/18/16, identitied R22 was severely cognitively impaired and had diagnoses which included, dementia, depression and reduced mobility. The MDS identified R22 required total assistance from staff for activities of daily living (ADL's). The MDS further identified R22 was at risk for pressure ulcer development, required pressure reduction	HALSTA	D LIVING CENTER					
development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement every two hour repositioning for 1 of 3 residents (R22) at risk for and with a history of pressure ulcer development who required staff assistance with repositioning. Corrected. Findings include: R22's quarterly Minimum Data Set (MDS) dated 7/18/16, identified R22 was severely cognitively impaired and had diagnoses which included, dementia, depression and reduced mobility. The MDS identified R22 required total assistance from staff for activities of daily living (ADL's). The MDS further identified R22 was at risk for pressure ulcer development, required pressure reduction	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLET DATE
ulcer development, required pressure reduction	2 900	development of a r provides that: A. a resident wh without pressure so pressure sores unl condition demonstria authenticates, that B. a resident w receives necessar promote healing, p new sores from de This MN Requirem by: Based on observat review the facility fa hour repositioning risk for and with a l of 3 residents (R31 development who repositioning. Findings include: R22's quarterly Mir 7/18/16, identified impaired and had of dementia, depress MDS identified R22 staff for activities of	hursing care plan which ho enters the nursing home cores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and who has pressure sores ry treatment and services to revent infection, and prevent veloping. hent is not met as evidenced tion, interview and document ailed to implement every two for 1 of 3 residents (R22) at history of pressure ulcers and 1) at risk for pressure ulcer required staff assistance with himum Data Set (MDS) dated R22 was severely cognitively diagnoses which included, ion and reduced mobility. The 2 required total assistance from f daily living (ADL's). The MDS	1			
Review of R22's current care plan dated 7/17/16, identified R22 was at high risk for pressure ulcer development due to impaired mobility and		devices for chair an Review of R22's cu identified R22 was	nd mattress surfaces. urrent care plan dated 7/17/16, at high risk for pressure ulcer				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		IRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 28	2 900			
	pressure ulcer inter pressure air relieving p directed facility staf reposition at least e with 2 staff assistar Review of a tissue the skin and its sup the effects of press dated 7/26/16, iden and was able to tole repositioning.	tolerance (TT), the ability of oporting structures to endure sure, without adverse effects, tified R22's skin was intact				
	revealed R22 conti from staff for daily or revealed R22 was a breakdown, was free	nued to require assistance cares and needs. The note				
	revealed R22 had 3 (non-blanchable er coccyx which meas 0.75 cm. The note	ound note dated 6/21/16, 3 stage I pressure ulcers ythema of intact skin) on her sured 0.75 centimeters (cm) x revealed a pressure relieving emented to aid in healing.				
		ound note dated 7/1/16, ssure ulcers were healed.				
		ound note dated 7/17/16, at high risk for pressure ulcer				
anosota D	R22 had been adm	n note dated 7/21/16, revealed itted to hospice care due to ndition and dementia.				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
HALSTA	D LIVING CENTER			EAST		
			D, MN 56548		000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 29	2 900			
	Review of R22's progress notes form 2/4/16, to 7/29/16, revealed weekly skin assessment from which revealed R22's skin was intact. R22 required a turning and repositioning program and preventative skin care due to risk for pressure ulcer development. In addition R22's progress notes revealed the following:					
		R22 had open areas on her sing was applied by the night				
	open area on her c ulcer. The note rev mattress was place	R22 continued to have an occyx which was a pressure ealed an air alternating ed on R22's bed for pressure d to require a turning and				
		22's pressure ulcer on her since air mattress was placed				
	repositioning. On 8 observations 7:01 a observed to be toil	and 35 minutes without /3/16, during continuous a.m. 9:20 a.m. R22 was not leted. On 8/3/16 at 9:25 a.m. NA)-A stated R22 was up in the a.m.	3			
	space wheelchair. seated in a tilt in sp rehabilitation aide (verbalized to the m move R22 back in R22 to her room. R	a.m. R22 was seated in a tilt in At 7:22 a.m. R22 remained bace wheelchair. At 7:31 a.m. RA)-A stood behind R22 and edication nurse she would her wheelchair. RA-A brought RA-A stated R22 needed to be				
	then asked R22 to	her tilt in space chair. RA-A lean forward and used the slacks to pull her buttocks				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00764	B. WING		08/	04/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		IRTH AVENUE D, MN 56548	EAST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ige 30	2 900			
	R22's head rest and wheelchair back to nurses station. RA- assist R22 with rep At 8:05 a.m. R22 re space wheelchair. I approached R22, s breakfast time. NA- R22 repositioning. J (RN)-A walked over about breakfast. RN R22 without offering a.m. licensed pract approached R22 ar medications. LPN-A room and NA-A too LPN-A and NA-A dia assistance with car seated in her tilt in the dining room frou 8:54 a.m. NA-A ass room and back to th nurses station. Acti go fold towels in the and AA-A provided 9:04 a.m. R22 remain in the activity room was observed to off NA-A entered the a observed to approa assisted R22 in her she turned on R22's entered R22's room 9:20 a.m. NA-A and with the mechanica bathroom. When N buttocks had multip	the chair. RA-A then adjusted d assisted R22 in her the common area by the A was not observed to offer or ositioning to off load pressure. emained seated in the tilt in Nursing assistant (NA)-A tated to R22 that it was almost -A was not observed to offer At 8:10 a.m. Registered nurse r to R22 and spoke with her N-A then walked away from g R22 repositioning. At 8:13 ical nurse (LPN)-A nd administered her A moved R22 toward the dining k R22 to the dining room. d not offer repositioning or es at that time. R22 remained space wheelchair at a table in m 8:14 a.m. to 8:54 a.m. At sisted R22 out of the dining he common area by the vity aid (AA)-A offered R22 to e activity room. R22 accepted a pile of towels for folding. At ained seated in her wheelchair and folded towels. No staff fer repositioning. At 9:16 a.m. ctivity room and was not uch R22. At 9:19 a.m. AA-A wheelchair to her room where s call light. NA-A and NA-B n with the mechanical lift. At d NA-B assisted R22 to stand d lift and brought R22 into the A-A removed R22's brief, her ole deep creases on both kin on her buttocks was dark				

Minnesota Department of Health STATE FORM

6899

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED	
		00764	B. WING		08/	08/04/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
HALSTA	D LIVING CENTER		RTH AVENUE	EAST			
			D, MN 56548				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ige 31	2 900				
	been repositioned a shift got her up for supposed to be rep because of skin brea had some skin brea and had healed qui	a.m. NA-A stated R22 had last at 6:45 a.m. when the night the day. NA-A stated R22 was positioned every 2 hours eakdown. NA-A stated R22 akdown at least a month ago ckly once they gave her a new ted R22 needed total ositioning.					
	total assistance wit hours. NA-C stated	a.m. NA-C stated R22 required h repositioning at least every 2 R22 had skin breakdown on the last month or two and it					
	interview NA-A stat hospice NA had as he was there for ca when R22's hospic responsible for repo aware he had not d would usually verba hospice aid on wha	a.m. during a follow up ed she had thought R22's sisted R22 to reposition when res that morning. NA-A stated e aide would come he was ositioning. NA-A was not one so. NA-A stated she ally communicate with the t was done for R22 though did me. NA-A stated she was busy o ensure R22 was					
	practice for residen was for the NA's to cares were provide NA leaving. RN-A c revealed no cares w hospice aid. RN-A s with repositioning a stated R22 continue	a.m. RN-A stated the usual ts who received hospice care verbally communicate what d for R22 prior to the hospice onfirmed the hospice NA note were provided to R22 by the stated R22 required assistance t least every 2 hours. RN-A ed to be at high risk for skin d a few "superficial" areas on					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		IRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	her coccyx in 6/16 y RN-A stated she fe R22's coccyx were because they had r pressure relieving r an intervention at th R22's care plan wa assist R22 with assist toileting needs. On 8/3/16, at 10:59 (DON) confirmed F ulcers. The DON st follow R22's care p repositioning at lease Review of facility po Positioning, revised facility's procedure repositioning needs care plan based on skin breakdown, pr pressure relief for r R31's quarterly Min 5/23/16, identified F impairment, require activities of daily liv lower extremity imp identified R31 was and bladder and was pressure ulcers and device for his chair. R31's care plan dat the potential for alte to impaired physical integrity, incontinen and multiple medic.	which had healed by 7/16. It the superficial areas on stage one pressure ulcers no depth. She indicated a mattress was put into place as nat time. RN-A confirmed s current and directed staff to sessed repositioning and a.m. the director of nursing 22 was at risk for pressure tated she expected staff to lan for the assessed need of st every 2 hours. blicy and procedure titled, d 3/2009, revealed it was the to evaluate resident s, develop an individualized assessed need to prevent omote circulation and provide esidents. himum Data Set (MDS) dated R31 had moderate cognitive ed extensive assistance with al ing (ADLs) and had upper and pairment. The MDS also always incontinent of bowel as at risk for developing d had a pressure relieving		DEFICIENC	Υ)	

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		RTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	staff to turn and rep 2 hours and as nec R31's care area as 12/7/15, identified F pressure ulcers as assistance with AD bowel and bladder Review of R31's pro- clinical assessment 5/23/16, which inclu- evaluate pressure of placed him at risk for break down. R31 w bladder, had a histor groin and arm pit, w	osition in bed and chair every	2 900			
	Kardex Report which assistant care guide	v form titled Visual/Bedside ch served as a nursing e, directed staff to turn and ry two hours when in bed and				
	to 8:00 p.m. identifi or repositioned in h p.m. R31 was seate room table waiting Resident's chair wa 5:47 p.m. licensed administered R31's was fed his meal by 6:13 p.m. NA-I brok handed half to him. his cookie on was of At 6:29 p.m. NA-E	ation on 8/2/16, from 5:21 p.m. ed R31 had not been offered is chair. On 8/2/16, at 5:21 ed in the dining room at dining for his evening meal. Is in an upright position. At practical nurse (LPN)-B medication. At 6:00 p.m. R31 y nursing assistant (NA)-H. At ke R31's cookie in half and NA-I told R31 the other half of on his plate and walked away. tilted R31's wheelchair back d him from the dining room to				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	-	
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
IAG			IAG	DEFICIENC		
2 900	Continued From pa	age 34	2 900			
	the day area. At 6:37 p.m. R in the day area, asleep in his R31 continued seated in the p.m. NA-G pulled R31's shii as his lower belly was expose loud to herself, "I think we'll I bed soon, I'll have to check w see what she says." R31's h forward and to the left, off of 8:00 p.m., after surveyor inter laid down. Observation revea were red with creases in but thighs. At that time, RN-B sta blanchable and the scars ob buttocks were from R31's his On 8/2/16, at 7:56 p.m. NA-C assigned to R31's care for th stated she didn't know exact repositioned, but stated it was	R31's shirt down over his belly vas exposed. NA-G stated out nink we'll have to put him to to check with my partner and ." R31's head was hanging left, off of the head rest. At rveyor intervention, R31 was ation revealed R31's buttocks ses in buttocks and upper , RN-B stated the redness was a scars observed on the n R31's history of boils. p.m. NA-G stated she was was care for that evening. She now exactly when R31 was last tated it was sometime before ed R31 was supposed to be	6			
	bed. She stated be chair she considere confirmed she did She stated she did	2 hours when in his chair or ecause R31 was asleep in his ed that a refusal. She not offer R31 repositioning. n't know if R31 was at risk for cause that was up to the				
	confirmed R31's ca have been reposition confirmed R31's la (the ability of the sk structures to endur without adverse eff 12/3/15, and idention repositioning. She	a.m. registered nurse (RN)-B are plan and stated R31 should oned every 2 hours. She st tissue tolerance test (TTT) kin and its supporting re the effects of pressure, fects) was completed on ified R31 required every 2 hour confirmed R31's Braden score at risk for developing pressure	r			

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
			B. WING			
		00764			08/	04/2016
	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ JRTH AVENUE			
IALSTA	D LIVING CENTER		D, MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From pa	age 35	2 900			
	confirmed the reas repositioning was t skin breakdown. S and was unable to confirmed R31 req assistance from sta confirmed R31 wor pressure from his k without staff assist charge nurse last r and reposition R31 On 8/3/16, at 10:54 assistant (TMA)-B for developing pres a history of skin issist stated current inter intact were to repo use barrier cream should be repositio R31 was totally de mobility and reposi plan directed staff every 2 hours. On 8/3/16, at 11:48 confused and was cares. She stated to reposition him e areas. She stated staff for developing press On 8/3/16, at 11:10 (DON) stated R31 pressure ulcers an 2 hours. The DON extensive assistant	4 a.m. trained medication stated she felt R31 was at risk soure ulcers and stated he had sues on his bottom. TMA-B rventions to keep R31's skin sition R31 every 2 hours and on his bottom. She stated R31 oned every 2 hours. She stated pendent on staff for bed itioning. She stated R31's care to turn and reposition R31 B a.m. NA-D stated R31 was totally dependent on staff for R31's care plan directed them very 2 hours to prevent open she didn't think R31 was at risk	r			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00764	B. WING		08/	04/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	ge 36	2 900			
	She stated she wou plan of care and rep prevent the develop	aired communication skills. uld expect staff to follow the position R31 every 2 hours to oment of pressure ulcers.				
	Positioning, revised facility's procedure repositioning needs care plan based on	blicy and procedure titled, l 3/09, revealed it was the to evaluate resident s, develop an individualized assessed need to prevent omote circulation and provide esidents.				
	The director of nurs develop systems to appropriately preve developed. The DC all appropriate staff develop monitoring	THOD FOR CORRECTION: sing (DON) or designee could ensure pressure ulcers are nted and/or treated as N or designee could educate . The DON or designee could systems to ensure ongoing port results to the quality ee.				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21))			
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			8/26/16
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	This MN Requiremo	ent is not met as evidenced				

STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENU D, MN 56548	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ige 37	2 920			
	review the facility fa hours check and ch	ion, interview and document ailed to implement every two nange incontinence program (R22) reviewed with		Corrected.		
	Findings include:					
	7/18/16, identified F impaired and had c dementia, depressi MDS identified R22 staff for activities of	imum Data Set (MDS) dated R22 was severely cognitively liagnoses which included on and reduced mobility. The required total assistance from f daily living (ADL's). The MDS 22 was frequently incontinent pileting program.				
	7/24/16, directed fat toileting at least even	rrent care plan revised acilty staff to assist R22 with ery 2 hours and to check R22's ery 2 hours for total bowel and ce.				
	7/24/16, identified F of bowel and bladd	rly nursing assessment dated R22 was frequently incontinent er and required total aff with incontinence cares as e plan.				
	toileting. On 8/3/16 observations 7:01 a observed to be toil	a.m. 9:20 a.m. R22 was not eted. On 8/3/16 at 9:25 a.m. NA)-A stated R22 was up in the				
	space chair. At 7:28 a tilt in space chair	.m. R22 was seated in a tilt in 8 a.m. R22 remained seated ir near the nurses station. At tion aide (RA)-A assisted R22				

	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00764	B. WING		08/	04/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	R22 was boosted b RA-A. RA-A adjuste assisted R22 in her common area by th not observed to che incontinent brief. At seated in the tilt in s approached R22, s breakfast time. NA- assistance with toile practical nurse (LP administered her m R22 to the dining ro not offered assistan checking and chang dining room until 8: R22 out of the dinir common area by th (AA)-A offered R22 room. R22 accepte towels for folding. A seated in her whee staff had been obse check and changing the activity room. N	her room. Once in her room, back in her wheelchair by ed R22's head rest and wheelchair back to the he nurses station. RA-A was eck and/or change R22's 8:05 a.m. R22 remained space wheelchair. NA-A tated to R22 that it was almos A did not offer R22 eting. At 8:13 a.m. licensed N)-A approached R22 and hedications. NA-A then took bom for breakfast. R22 was noce with repositioning or with ging. R22 remained in the 54 a.m. NA-A then assisted ng room and back to the he nurses station. Activity aid to go fold towels in the activity d and was provided a pile of At 9:04 a.m. R22 remained lchair in the activity room. No erved to offer repositioning or g. At 9:16 a.m. NA-A entered A-A was not observed to				
	9:19 a.m. AA-A app all of the towels, an go back to her room then assisted R22 i where she turned o NA-B entered R22's At 9:20 a.m. NA-A stand with the mech into the bathroom v	ifer assistance with cares. At proached R22, she had folded d asked her if she wanted to n, R22 had replied yes. AA-A n her wheelchair to her room on R22's call light. NA-A and s room with the mechanical lift and NA-B assisted R22 to hanical lift and brought R22 with the mechanical lift. NA-A pontinent brief which was wet				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00764	B. WING		08/	04/2016
NAME OF I	AME OF PROVIDER OR SUPPLIER STREET AD			TATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 39	2 920			
	been repositioned at 6:45 a.m. when the night shift helped her get up for the day. NA-A stated R22 was supposed to be repositioned and checked and changed at least every 2 hours because of skin breakdown. NA-A stated R22 needed total assistance with repositioning and toileting needs.					
		a.m. NA-C stated R22 required h repositioning and checking ast every 2 hours.	E E			
	interview NA-A stat NA had assisted wi there for cares that R22's hospice aide responsible for rep changing R22. NA- not done so. NA-A verbally communication	a.m. during a follow up red she thought R22's hospice ith repositioning when he was morning. NA-A stated when was there, he was ositioning and checking and A and was not aware he had stated she would usually ate with the hospice aid on R22 though did not do it this				
	practice for residen was for the NA's to cares were provide NA leaving. RN-A s revealed no cares hospice aid. RN-A	a.m. RN-A stated the usual ats who received hospice care verbally communicate what d for R22 prior to the hospice stated the hospice NA note were provided to R22 by the stated R22 required assistance checking and changing at leas				
	(DON) stated she e care plan for her as	a.m. the director of nursing expected staff to follow R22's ssessed need of repositioning changing at least every 2				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00764		B. WING		08/04/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
HALSTA	D LIVING CENTER		JRTH AVENU D, MN 56548	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ge 40	2 920			
	bathroom/commod revealed the policy	policy and procedure titled, e assisting, revised 11/03, directed facility staff that all e assisted with toileting needs				
	The director of nurs develop systems to assistance with toile services. The DON appropriate staff. T develop monitoring	HOD FOR CORRECTION: sing (DON) or designee could ensure residents requiring eting receive the necessary or designee could educate all he DON or designee could systems to ensure ongoing port those results to the quality ee.				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21))			
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			8/26/16
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review the facility fa experience with the	ent is not met as evidenced on, interview and document alled to provide a dignified a utilization of a catheter for 1)reviewed with a catheter.		Corrected.		
	Findings include:					
	R31's quarterly Min	imum Data Set (MDS) dated				

STATE FORM

KMB911

If continuation sheet 41 of 45

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
00		00764	B. WING		08/	04/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	D LIVING CENTER	133 FOU	RTH AVENUE	EAST		
HALSTA	D LIVING CENTER	HALSTAD), MN 56548			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ge 41	21805			
	impairment, require activities of daily liv lower extremetity in	R31 had moderate cognitive ed extensive assistance with all ing (ADLs) and had upper and npairment. The MDS also always incontinent of bowel				
	an indwelling cathe inability to void for e was to monitor for o Foley catheter mon weeks. The care pl	ted 7/7/16, identified R31 had ter placed 7/5/16, for an extended periods of time. Staff odorous urine, change the thly and the Foley bag every 2 an failed to identify additional cleaning or irrigating the				
	in his room in front bag contained in a	o.m. R31 was in his wheelchair of the TV. R31 had a catheter cloth bag on the side of his bedroom had a strong, foul, odor.				
	asleep with the cath cloth bag which sat small silver pitcher and empty urinal we R31's bedroom and	a.m. R31 was observed in bed neter collection bag inside a on the floor next to his bed. A to measure urine output and ere on the back of R31's toilet. d bathroom continued to have entrated urine odor.				
	stated R31 required activities of daily liv good decision mak of R31's urine odor started soon after F She stated she felt tube that could be catheter should be	a.m. registered nurse (RN-B) d extensive assistance with all ing (ADLs) and was not a cer. She stated she was aware and stated the urine odor R31's catheter was placed. there was sediment in the causing the odor and the gone through to check what ine odor. She stated R31's				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00764		B. WING		08/04/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
HALSTA	D LIVING CENTER		JRTH AVENUE D, MN 56548	EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	ige 42	21805				
	urine was "a little thicker" because he was on thickened liquids. RN-B stated R31 didn't drink enough fluids which contributed to R31's urine odor problem. She stated there were things they could have tried to limit R31's urine odor such as irrigating with vinegar, or changing the catheter entirely. She stated the catheter is changed monthly and the bag twice per month. RN-B stated the nursing assistant's (NA's) wash R31's perineal area with soap and water twice a day with cares and as needed if they noticed odor. RN-B stated nursing was responsible for the insertion and equipment. She confirmed the last time nursing changed the catheter bag was on 7/20/16.						
	assistant (TMA)-B a decision maker as stated R31 was tota cares. TMA-B state had an odor becaus stated his urine in t started with the initi stated when she no would have to char know if she told the before today. She s odor. She stated sh with soap and wate	a.m. trained medication stated R31 was not a good his cognition wasn't good. She ally dependent on staff for ed R31's urine was dark and se he didn't drink enough. She he bag is dark and the odor iation of the catheter. She oticed the odor the nurses age it. TMA-B stated she didn't e nurse about R31's odor stated all catheters had an he washed R31's perineal area er, emptied R31's foley bag and 't rinse out the bag but closed					
	interview RN-B stat bag, emptied the bay washed surroundin She confirmed NA's it was emptied. She	a.m. during a follow-up ted NA's open the catheter ag and closed the bag and g skin with soap and water. s didn't rinse out the bag after e stated the LPN was lating with vinegar during the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00764		00764	B. WING		08/04/2016	
NAME OF PROVIDER OR SUPPLIER STREET			DRESS, CITY, ST	TATE, ZIP CODE		04/2010
IALSTAD	LIVING CENTER		RTH AVENUE), MN 56548	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21805	know where the od stated the odor hu She stated when sh day it was really ba changed his cathet talked to the night r her to irrigate the tu stated she felt it he On 8/3/16, at 11:48 R31's urine odor to She stated she was soap and water and She confirmed she emptied it. She stat totally dependent o she agreed with Sh had the same odor On 8/3/16, at 12:25 urine odor in R31's confirmed the urine from the pitcher an toilet which were us R31's catheter bag from the cloth bag cc of light brown ur urine odor was from stated she felt R31 there were no "chu don't rinse the bag have caused more have rinsed the bag bag, and rinsed the used 2 different bag	ift. RN-B stated she didn't or was coming from and ng in the bag and in the tubing. he noticed the odor the other d and she should have er at that time. She stated she hurse the other night and had ubing with plain water and lped. a.m. NA-D stated she noticed day and shelly told the nurse. shed R31's perineal area with d emptied the catheter bag. didn't rinse the bag after she ted R31 was confused and n staff for cares. She stated helly and she felt all catheters f. p.m. RN-B confirmed strong bedroom and bathroom. RN e odor in the bathroom was d urinal on the back of R31's sed to measure urine from . RN lifted R31's catheter bag. on the floor that contained 120 ine and confirmed the strong n R31's catheter bag. She s's urine looked pretty good as nks in it". She stated the NA's after emptying which would odor. She stated they could g after emptying, used a leg bag every day with vinegar, gs alternating, or try odor erdent tablets in the bag to	21805			
nesota De	On 8/3/16, at 1:10 partment of Health	o.m. DON stated R31 was				

00764 B. WING 08/04/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08/04/20 HALSTAD LIVING CENTER 133 FOURTH AVENUE EAST HALSTAD, MN 56548 133 FOURTH AVENUE EAST HALSTAD, MN 56548 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM	STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HALSTAD LIVING CENTER 133 FOURTH AVENUE EAST HALSTAD, MN 56548 (K4) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WUST BE PRECODED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WUST BE PRECODED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WUST BE PRECODED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COULT (ID COULT AG (ID PREFIX TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COULT (ID COULT AG (ID PREFIX TAG ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (ID CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COULT (ID CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COULT (ID CROSS-REFERENCED (ID CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COULT (ID CROSS-REFERENCED (ID CROSS-REFER				_			
BALSTAD. IVING CENTER 133 FOURTH AVENUE EAST (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION EGTION EGTION (EACH DEFICIENCY MUST BE PRECEDEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY PREFIX TAG CONTINUE APPROPRIATE DEFICIENCY CONTINUE APPROPRIATE DEFICIENCY 21805 Continued From page 44 21805 21805 Image: Colspan="2">Continued From page 44 21805 21805 Continued From page 44 21805 Image: Colspan="2">Continued From page 44 21805 21805 Continue droin staff for cares and had alterations in his thought processes and communication. She stated she would expect staff to follow the plan of care and R31 to be free of urine odor. She stated she was not aware that R31 had urine odor until today. Review of, "Your Rights Under The Combined Federal and Minnesota Residents Bill of Rights," dated 7/1/07, identified the facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure residents have a dignified experience when utilizing catheters. The DON or designee could develop monitoring systems to ensure ongoing Image: Colspan="2">Colspan=Could develop monitoring systems to ensure ongoing <th></th> <th></th> <th>00764</th> <th>B. WING</th> <th></th> <th>08/</th> <th>04/2016</th>			00764	B. WING		08/	04/2016
HALSTAD LIVING CENTER HALSTAD, MN 56548 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COULD COOSS-REFERENCED CO	NAME OF F	PROVIDER OR SUPPLIER					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 44 21805 21805 Continued From page 44 21805 21805 Intel Appropriate DEFICIENCY) Intel Approp	HALSTA	D LIVING CENTER			EAST		
 totally dependent on staff for cares and had alterations in his thought processes and communication. She stated she would expect staff to follow the plan of care and R31 to be free of urine odor. She stated she was not aware that R31 had urine odor until today. Review of, "Your Rights Under The Combined Federal and Minnesota Residents Bill of Rights," dated 7/1/07, identified the facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure residents have a dignified experience when utilizing catheters. The DON or designee could develop monitoring systems to ensure ongoing 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
alterations in his thought processes and communication. She stated she would expect staff to follow the plan of care and R31 to be free of urine odor. She stated she was not aware that R31 had urine odor until today. Review of, "Your Rights Under The Combined Federal and Minnesota Residents Bill of Rights," dated 7/1/07, identified the facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure residents have a dignified experience when utilizing catheters. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing	21805	Continued From pa	age 44	21805			
assurance committee. TIME PERIOD FOR CORRECTION: Twenty (21) days.		alterations in his th communication. Sh staff to follow the p of urine odor. She s R31 had urine odor Review of, "Your R Federal and Minne Residents Bill of Ri the facility must wit for you in a manne maintains or enhar full recognition of y SUGGESTED MET The director of nurs develop systems to dignified experienc DON or designee of staff. The DON or of monitoring systems compliance and rej assurance committed	ought processes and he stated she would expect lan of care and R31 to be free stated she was not aware that r until today. ights Under The Combined sota ights," dated 7/1/07, identified th courtesy promote and care r and environment that nees your dignity and respect in our individuality. THOD FOR CORRECTION: sing (DON) or designee could b ensure residents have a the when utilizing catheters. The could educate all appropriate designee could develop is to ensure ongoing port those results to the quality tee.				