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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KMB9
Facility ID: 00764

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245569**
2. STATE VENDOR OR MEDICAID NO. (L2) **075740300**

3. NAME AND ADDRESS OF FACILITY
(L3) **HALSTAD LIVING CENTER**
(L4) **133 FOURTH AVENUE EAST**
(L5) **HALSTAD, MN** (L6) **56548**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **11/21/2016** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 09/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/03/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1991** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/23/2016** (L33)

DETERMINATION APPROVAL

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, 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 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

An equal opportunity employer.

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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245569	A. Building B. Wing	11/21/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 09/08/2016	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 09/08/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 09/08/2016
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 09/08/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 09/08/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 09/08/2016
ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 09/08/2016	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

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) GA/mm	DATE 12/05/2016	SIGNATURE OF SURVEYOR 32603	DATE 11/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/4/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245569	A. Building 01 - MAIN BUILDING 01 B. Wing	9/2/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 08/09/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 08/09/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 08/09/2016
ID Prefix Reg. # NFPA 101 LSC 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

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TL/mm	DATE 12/05/2016	SIGNATURE OF SURVEYOR 36536	DATE 09/02/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/8/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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 / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
00764	A. Building B. Wing	11/21/2016

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).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix 20510 Reg. # MN Rule 4658.0300 Subp. 2 LSC	Correction Completed 09/08/2016	ID Prefix 20520 Reg. # MN Rule 4658.0300 Subp. 3 B LSC	Correction Completed 09/08/2016	ID Prefix 20530 Reg. # MN Rule 4658.0300 Subp. 4 LSC	Correction Completed 09/08/2016
ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	Correction Completed 09/08/2016	ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 09/08/2016	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 09/08/2016
ID Prefix 20920 Reg. # MN Rule 4658.0525 Subp. 6 B LSC	Correction Completed 09/08/2016	ID Prefix 21805 Reg. # MN St. Statute 144.651 Subd. 5 LSC	Correction Completed 09/08/2016	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

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) GA/mm	DATE 12/05/2016	SIGNATURE OF SURVEYOR 32603	DATE 11/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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 all 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 https://dab.efile.hhs.gov/. 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 https://dab.efile.hhs.gov/user_sessions/new 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 **all** 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 no later than 60 days 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

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F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, the facility failed to resolve 1 of 22 Stage 2 residents (R33) grievance. Specifically, R33 expressed a complaint regarding a lack of assistance from staff to walk with her to promote her goal of becoming more independent. Findings include: The "(Facility) Grievance Policy and Procedure for Resident and Families" indicated it was the policy of the facility, "to encourage residents and family to communicate verbally or in writing any concerns, problems, or recommend changes relating to care or to report a violation of the resident bill of rights." Recommended steps included discussing the matter first with the supervisor of the department involved. For the department of nursing, the Charge Nurse or Director of Nursing (DON) were identified as being the contact persons. If issues were not resolved, a grievance form could be completed by the resident. All grievances would be addressed in no more than 7 working days. R33 was admitted to the facility on 1/30/15. Current diagnoses, from the 4/4/16 quarterly Minimum Data Set (MDS) assessment, included	F 166	F0166 It is the policy of Halstad Living Center to encourage residents and family to communicate verbally or in writing any concerns, problems, or recommend changes relating to their care, or to report a violation 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 are expressed either verbally or in writing. In addition to R33's FMP(functional maintenance program), which includes ambulation, an additional ambulation program was added to her Plan of Care by her primary RN (Resident Care Coordinator) for staff to offer to assist R33 to ambulate at least 1 additional time on the AM shift, and at least 1 time on the PM shift everyday. All staff working that day and upon next working day, reeducated regarding Residents Rights and their right to have prompt efforts to resolve their grievances by DON and SSD. All other remaining staff reeducated on or before 9-16-16 by DON and/or SSD. Audits will be conducted by speaking to	9/16/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 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.

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F 166	Continued From page 1 anemia, heart failure, and high blood pressure. Review of the quarterly Minimum Data Set (MDS) dated 6/27/16 and annual MDS dated 1/11/16 demonstrated the resident was cognitively intact with a Brief Interview for Mental Status (BIMs) score of 15 (score of 13-15 consistent with cognitively intact per the Resident Assessment Instrument). The resident was coded as being free of both mood and behavior symptoms. The 6/27/16 and 1/11/16 MDS indicated the resident required extensive assistance of one person for walking in her room and in the corridor. The resident was coded as not steady and only being able to stabilize with staff assistance for: balance from seated to standing, walking, turning around facing opposite direction, and moving off the toilet. The resident was coded as using both a walker and wheelchair for mobility. R33 was interviewed on 8/24/16 at 9:35 a.m. and stated, "I don't get the walking I want." The resident stated it was very important to her to walk more in order to increase strength and improve her ability to walk. She stated her goal was to be able to walk with a walker rather than being dependent on a wheel chair for mobility. R33 reported she was walked between 3 to 5 times a week by the Restorative Aide. R33 stated, "Not very often do I get to walk to the dining room and especially on the weekends. I would like to walk more with the CNAs." The resident stated, "I feel I sit too much." The resident reported she had not used a wheelchair for mobility prior to her admission to the facility about a year and a half ago. The resident stated, "I was walking with a walker and was not in a wheelchair. They (facility) said come here for therapy due to my weakness and I got put in a wheelchair and that is what happened. I did	F 166	R33 to make sure she is satisfied with her walking program by SSD/Designee 3x/wk for 1 month, and then randomly thereafter to ensure continued compliance. This has the potential to affect any/all residents 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 be reviewed with all new employees upon hire. SSD will emphasize grievance policy and procedure to the current residents at the next Resident Council meeting, and individually if they do not attend, and each Resident Council meeting thereafter as part of their regular meeting. Special emphasis on the Grievance policy and procedure will be reviewed with new admissions per SSD and/or Designee. Audit results will be brought to the QA committee quarterly by Social Service Designee for further review/suggestions until 100% compliance is sustained for 6 months.	

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F 166	Continued From page 2	F 166		

therapy till I reached my goal. They said I reached the goal." The resident stated, "They say they are working on it (implementing a more frequent walking program)." The resident stated she expressed her complaint about wanting to walk more with staff in her care plan meeting and to a number of staff including the Restorative Aide, the Charge Nurse, the DON and to the Social Service Designee (SSD), but she did not know what the outcome of her complaint was. The resident was asked if she filed a formal grievance using the "Concern/Grievance Report." The resident denied filling out a grievance report; however, stated she verbally expressed her complaint to a number of staff at different times and it had not been resolved.

Record review confirmed the resident's desire to walk more. According to a 7/7/16, "Plan of Care" note, "(R33) also stated that she wants to walk to meals and that staff should know that she wants to walk more."

The Social Service Director (SSD) was identified by administration as being the staff member in charge of the grievance procedure. The SSD was interviewed on 8/25/16 at 11:43 a.m. and stated she was aware of the resident's desire to walk more. The SSD stated this was discussed at the resident's care conference. The SSD stated, "(The resident) brought it up at care conference. Nursing has discussed it and said they would walk the resident to meals and to the bathroom. It was quite a while ago." The SSD stated the Restorative Director walked the resident but the CNAs should also be walking her. The SSD stated no formal written grievance had been filed. She further stated a grievance should be initiated if a resolution to a complaint could not be worked

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F 166	Continued From page 3 out within a few days. The SSD stated she was not aware the issue was still a concern.	F 166		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure 3 (R28, R13, and R31) of 5 residents reviewed for activities in the Stage 2 sample of 28 resident received an adequate program of activities to meet their needs. Findings include: 1. R28 was admitted to the facility on 6/17/14 with diagnoses, according to the 8/25/16 "Diagnosis Information," of Parkinson's Disease, depression, encephalopathy, dementia with behavioral disturbance, bipolar disorder, and anxiety. The Quarterly Minimum Data Set (MDS - a comprehensive assessment completed by facility staff that drives the care planning process), with an assessment reference date (ARD) of 7/18/16, documented R28 had impaired cognition and exhibited signs and symptoms of depression. He had adequate hearing and impaired speech. R28 was observed throughout the survey to be	F 248	F248 It is the policy of Halstad Living Center to provide an ongoing program of activities designed to meet the interests and physical, mental and psychosocial well-being of each resident. Activity Director reassessed residents R13, R28, and R31 to ascertain specific interests and needs on 9-15-16. Input from residents, family, nursing staff and activities staff was included in reassessment. Specific leisure interests were addressed in care plans for residents 13, 28, and 31. The activity calendar is developed and one to one visits are assigned based on residents' assessed strengths, leisure interests, needs and interventions. The findings of this assessment are reflected in each resident's care plan. Activity Director will reassess and audit all residents' activity care plans by 12-15-16. Activity staff were reeducated by Activity Director regarding Philosophy of the	9/15/16

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F 248	Continued From page 4 seated in his wheelchair in the common area in front of the nurses' station. On 8/22/16 from 2:20 p.m. to 4:00 p.m., R28 was observed seated in common area without any interaction with staff or residents or any type of stimulation, such as music. On 8/23/16 from 9:00 a.m. to 11:00 a.m. and again from 2:00 p.m. to 3:00 p.m., R28 was observed seated in common area without any interaction with staff or residents or any type of stimulation. On 8/24/16 from 9:50 to 12:07 p.m., R28 was observed seated in common area without any interaction with staff or residents or any type of stimulation. He was observed sleeping intermittently. On 8/23/16 at 9:32 a.m., an interview was attempted with R28. He was unable to answer interview questions, though he did nod his head "yes" or "no" occasionally. When asked whether he attended activities at the facility, he did not respond. The 7/27/16 "Activities - Quarterly/Annual Participation Review" documented, "[R28] has attended 13 group activities over the past quarter and has participated in 15 [one to one] visits. He seems to enjoy some music events and will spend time watching the birds in the aviary... [R28] has enjoyed hand massage and watching some videos on YouTube during [one-to-one] visits. He spends time observing in the center area and will work with some of the building/crafting manipulatives available in the activity room." The assessment documented the resident's goals were met and the current interventions were appropriate.	F 248	Activities Department, one to one policy and documentation requirements on 9-12-16 and 9-15-16. All staff were in-serviced on residents' leisure interests and leisure needs on/before 9-16-16. Activity Director will audit current residents' and new admission' activity participation charting for each resident weekly for 3 months. One to one visits will be initiated if resident participation drops below 3-5 activities per week with little/no independent resident activities. (see attached) Activity Director will monitor for compliance by completing weekly audits of one to one visit records, data collection tools and task observation until 100% compliance is achieved. Activity Director will then follow up by completing bi-monthly and monthly audits to assure continued compliance. Results will be reported to the QA committee quarterly until 100% compliance is sustained for 6 months.	

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F 248	Continued From page 5	F 248		

The 5/13/16 activity "Care Plan" documented [R28] had a "Potential for social isolation [related to] anxiety, physical limitations, difficulty communicating due to trach placement." The goals were, "Resident will actively engage in [one-to-one] visit 1 [to] 2 times per week for social interaction and sensory stimulation through review date" and "The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date." The approaches included: "Assist resident to and from activities as needed...Introduce the resident to residents with similar interests and encourage/facilitate interaction...Invite/encourage resident's involvement in activities of choice/interest such as: music events, morning social time, outings, folding towels. [R28] 'likes to have a job'...Invite/encourage the resident's family members to attend activities with resident in order to support participation...Modify daily schedule, treatment plan [R28] to accommodate activity participation as requested by the resident...Monitor attendance...Monitor/document for impact of medical problems on activity level...Praise participation...Provide [one-to-one] visits 1 [to] 2 times weekly using iPad, reading newspaper, hand lotion...Provide resident with an activity calendar, highlight interests...Remind the resident that they may leave at any time and is not required to stay for entire activity...Respect resident's right to refuse...The resident needs assistance/escort to activities...When the resident chooses not to participate in organized activities, the resident prefers to watch TV, observe in the center area, and listen to music for social and sensory stimulation."

The One-to-One activity record documented R28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 6	F 248		

received one-to-one visits on:
8/22/16, 8/12/16, 8/11/16, 8/1/16, 7/22/16, 7/21/16, 7/11/16, 7/8/16, 7/2/16, and 7/1/16. Most of these visits were documented as "Sensory Stimulation."

The group activity participation record documented the resident attended group activities on 8/15/16, 8/10/16, 8/7/16, and 8/2/16.

On 8/25/16 at 3:16 p.m., the Activity Director (AD) stated R28 received one-to-one visits 1 to 2 times a week, and attended group activities 4 to 5 times a month. She stated she would like to see him attend more group activities, but sometimes in groups he coughed a lot and had to be removed. She stated his barriers to attending group activities were primarily that he spent a lot of time in bed or that he had to be removed from groups early so he did not disrupt the activity. The AD added she did not have the staffing levels to allow for more frequent one-to-one or small group interaction with the resident.

2. Review of R13's Quarterly MDS with an assessment reference date (ARD) of 8/1/16, documented R13 had a memory problem and severely impaired cognitive skills for daily decision making. R13's active diagnoses included but were not limited to dementia. R13 also had moderately impaired vision, adequate hearing, and unclear speech.

Review of R13's "Care Plan" with a "Focus" of "Potential for social isolation r/t dementia and depression manifested by end of life cares/hospice", revised on 5/12/16, documented the following "Interventions": "All staff to converse with resident while providing care. Encourage

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F 248	Continued From page 7	F 248		

ongoing family involvement. Invite the resident's family to attend special events, activities, meals. Provide with activities calendar. Notify resident of any changes to the calendar of activities. Respect dignity and end visit if signs and symptoms of discomfort or distress are displayed. Review resident's activation needs with the family/representative. The resident needs 1:1 bedside/in-room visits and activities if unable to attend out of room events. The resident prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as hand massage/lotion, music, reading poetry or short stories."

On 8/24/16 from 10:46am to 11:11am, R13 was observed seated in the television room by the common area. The television was observed to be turned on, but the resident was not observed watching the television at the time of the continuous observation. R13 was observed to have repetitive verbal behavior and was unable to answer surveyor questions.

On 08/25/2016 at 10:31am, R13 was observed seated in her wheelchair the television room with the television turned on. R13's eyes were observed to be closed.

On 08/25/2016 from 1:46pm to 2:55pm, R13 was observed seated in her wheelchair in the common area by the nurses' station. There were no diversional activities or interaction from staff.

Review of R13's "Quarterly Activity Assessment" dated 8/11/16, documented, "[R13] seems to respond more positively to 1:1 visits than any other interaction. She has been present 16 activities over the past quarter, most involving

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F 248	Continued From page 8	F 248		

music, and did not appear to have increased agitation or anxiety...[R13] seems to enjoy 1:1 interactions. She will hold a person's hand and at times her constant movements will stop or slow. [R13] has accepted hand massage and will give eye contact, at times, when someone sings to her ..."

Review of R13's "Quarterly Activity Assessment" dated 5/19/16, documented, "[R13] currently seems unable to tolerate participating in group activities. When seated near a group her level of agitation increases as evidenced by increased self-talk and body movements...She has been present for 9 activities over the last quarter but has not been able to participate in them...Will continue to provide 1:1 visits 1-2 times per week for social and sensory integration..."

Review of R13's documented group activities [untitled document] for February 2016 through August 2016, provided by the Activity Director on 8/22/16, indicated R13 participated in group activities on the following days: 2/3/16, 2/17/16, 2/24/16, 2/29/16, 3/28/16, 4/18/16, 4/25/16, 5/2/16, 5/17/16, 6/6/16, 6/20/16, 6/21/16, 6/22/16, 7/18/16, 7/26/16, 7/29/16, and 8/1/16.

Review of R13's documented 1:1 activities [untitled document] for February 2016 through August 2016, provided by the Activity Director on 8/22/16, indicated R13 participated in group activities on the following days: 2/5/16, 2/15/16, 2/23/16, 3/1/16, 3/8/16, 3/26/16, 4/1/16, 4/18/16, 4/23/16, 5/2/16, 5/6/16, 5/16/16, 5/23/16, 5/30/16, 6/2/16, 6/14/16, 6/20/16, 7/11/16, 7/18/16, 7/21/16, 7/26/16, and 8/22/16.

General observations on 8/22/16-8/25/16

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F 248	Continued From page 9 revealed numerous group and individual activities being conducted in the facility. R13 was not observed to attend any of the activities. During an interview on 8/25/16 at 11:01am the Activity Director stated that R13 enjoyed 1:1 activities and was to receive 1:1 visits 1-2 times a week. The Activity Director also indicated R13 benefit from low stimulation group activities, such as read and reminisce. The Activity Director further confirmed that R13 had not been receiving 1:1 visits as scheduled and would like for R13 to receive them more often. 3. Review of the Quarterly MDS with ARD of 8/15/16 revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicates R31 had a moderately impaired cognition. Further review of the Quarterly MDS dated 8/15/16 revealed that R31 was totally dependent on one staff member for locomotion on and off the unit. Review of the Annual MDS with an ARD of 12/7/15 revealed in section 0600 Activities that R31 stated that the availability of music and reading materials was very important. In an interview on 8/23/16 at 12:30pm, R31 stated when asked if he participated in activities that there were no activities. Observation of R31's room on 8/23/16 at 12:30pm revealed no reading materials present or music playing. Observation on 8/25/16 at 11:37am revealed that R31 was lying in his bed. There was no music playing or reading materials present.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 10	F 248		

Continued From page 10

Observations on 8/23/, 8/24 and 8/2516 revealed numerous activities being conducted, but R31 was not present for any of them.

Observation on 8/25/16 at 2:30pm revealed R31 lying in his bed, in his room with no books or reading materials present and no music playing.

Review of Care Plan for R31 revealed the following problem with an initiated date of 5/13/16 and a revision date of 8/22/16. The resident has little or no activity involvement related to altered thought process due to cardio vascular accident (CVA) and diagnosis of schizophrenia. The goal of the care plan was for the resident to express satisfaction with the type of activities and level of activity involvement when asked through the review date. Reviewing the interventions for this care plan revealed the following: Provide [one to one] 1:1 visits 1-2 times weekly and monitor attendance in activities.

Review of the undated "1-1 Visit Check Off Sheet" revealed that R31 was scheduled for 1:1 activities on Tuesdays and Thursdays.

Review of the documented group activities for June, July and August 2016 revealed the R31 had attended group activities three times in June, seven times in July and four times in August with the most recent group activity participation on 8/21/16.

Review of the document 1:1 activities provided in June, July and August in 2016 revealed that R31 had been provided 1:1 visits three times in June, two times in July and two times in August as of 8/24/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 11 In an interview on 8/24/16 the Activity Director stated that R31 was to receive 1:1 activity visits 1-3 times weekly and had not. In addition, the Activity Director stated that R31 should have received 1:1 activities 1-2 times a week and if the resident refused this should have been documented. In an interview on 8/25/16 at 11:30pm the Director of Nursing (DON) stated that she would expect that 1:1 activities be provided for R31 as care planned and if the 1:1 activities were not offered that there would be documentation as to the reason they were not.	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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.	F 280		8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to ensure the care plans for two of (R19 and R33) 28 residents in the Stage 2 sample were revised to accurately reflect their care and services. Specifically, R19's care plan was not updated with the use of a low bed as a fall intervention and to reflect an accurate number of actual falls and R33's care plan was not updated to reflect her desire to walk with the staff. Findings include: 1. R19 was admitted to the facility on 12/29/10 with diagnoses, according to the 8/24/16 "Medical Diagnosis" list, of Alzheimer's disease with behavioral disturbance, cataracts, arthropathy, glaucoma, transient cerebral ischemic attack, and fracture of the right humerus. The significant change Minimum Data Set (MDS - a comprehensive assessment completed by facility staff that drives the care planning process), with an Assessment Reference Date (ARD) of 8/2/16, documented R19 had severely impaired cognition and exhibited behavioral symptoms not directed toward others. She required extensive assistance with all activities of daily living and locomotion. R19 required assistance with balance and transfers and used a wheelchair for locomotion. R19 had experienced one fall with major injury since the previous assessment. The 8/1/16 "Morse Fall Scale" documented the resident was at high risk for falls related to having	F 280	F280 It is the policy of Halstad Living Center to complete a comprehensive care plan within 7 days after completion of the comprehensive assessment; prepared by the Interdisciplinary Team that includes the attending physician, a Registered Nurse, and other appropriate staff in disciplines as determined by each residents needs, & if practicable, the participation of the residents, family or legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment. Corrective action taken for R19 was to immediately update their plan of care (per primary RN Resident Care Coordinator) with the interventions that were already in use (but not added to care plan), which were 'bed in low position and mat on floor beside bed' and the interventions of R33's wishes/concern that was expressed regarding walking. An extra walking program was added to R33's plan of care per primary RN Resident Care Coordinator. This has the potential to affect any or all residents that reside here. The primary RN Resident Care Coordinators are responsible for continued updates/revisions of each individual residents care plan. Review of the facilities policy and procedures regarding updating the plan of care and specifically following the plan of care for each individual resident were reviewed with Licensed nursing by DON.	

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F 280	Continued From page 13 fallen before, having more than one diagnosis on the chart, impaired gait, and overestimating or forgetting her limits. An 8/3/16, 5:35 a.m. "Incident Note" documented, "Aides were doing round (sic) and found resident sitting on the floor beside her bed with her back resting against her bed. Bed was in the low position. She was easily assisted back to bed. No new injuries noted. She moved all extremities except for her right arm which she has a fractured (sic) from previous fall. [Neurological] checks were done and all was normal. Will continue to monitor with [neurological] assessments every 4 hours for 24 hours." The 8/3/16, 5:35 a.m. "Incident/Accident Report" documented R19 experienced an unwitnessed fall out of her bed. She was found sitting on the floor by her bed. The bed was in the low position. One recommendation for the team review was, "Continue with hi/low bed in lowest position while in the bed." On 8/24/16 at 2:30 p.m. and on 8/25/16 at 8:40 a.m., R19 was observed lying in a low bed in her room. The fall risk "Care Plan," initiated on 7/12/16 and revised on 8/23/16, documented "The resident is at risk for falls [related to] Unaware (sic) of safety needs, Confusion, Poor communication/comprehension, Wandering. Morse fall risk assessment is 75 on 8/1/16. [R19] is at a high [fall risk]. Suffered a fall with injury on 7/21/16. No other falls noted as of 8/1/16. The documented goal was, "The resident will be free from additional falls during the next assessment period." The interventions included: "Anticipate	F 280	DON/Designee will audit 3 resident care plans per week x1mo., then 5 residents monthly x1mo or until 100% compliance is achieved and sustained. Licensed nursing staff were re-educated, before survey team exited, by DON, regarding the importance of updating the plan of care immediately when interventions are put in place, per individual residents needs. Corrected 8-26-16. DON reviewed all current residents care plans, along with the residents primary RN, to ensure that all care plans were current and up to date with any interventions being used. Any negative patterns will be presented to the QA committee for further review/recommendations for 6 months.	

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F 280	Continued From page 14	F 280		

and meet The (sic) resident's needs...Be sure The (sic) resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance...Follow facility fall protocol...[Physical Therapy] evaluate and treat as ordered or [as needed]...Recent fall with fracture to [right] proximal humerus after fall on 7/21/16. Splint to [right] arm with follow up with Ortho. Resident using [wheelchair] at this time for locomotion on and off unit. Assist with 1 staff for [wheelchair] mobility."

R19's care plan did not document a low bed as a fall intervention, nor did it reflect she had experienced a fall on 8/3/16.

On 8/25/16 at 10:41 a.m., Registered Nurse (RN) 2 stated the care plan should be updated after falls and should have reflected the use of the low bed, and she would update the care plan immediately.

Review of the facility's "Falls: Assessment and Intervention" policy, written in November 2004 and reviewed September 2015, documented, "The RN will implement appropriate interventions. The interventions will be documented and placed on the Plan of Care immediately."

2. R33 was admitted to the facility on 1/30/15. Current diagnoses, from the 4/4/16 quarterly Minimum Data Set (MDS) assessment, included anemia, heart failure, and high blood pressure. Review of the quarterly Minimum Data Set (MDS) dated 6/27/16 and annual MDS dated 1/11/16 demonstrated the resident was cognitively intact with a Brief Interview for Mental Status (BIMs) score of 15 (score of 13-15 consistent with

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F 280	Continued From page 15	F 280		

cognitively intact per the Resident Assessment Instrument). The resident was coded as being free of both mood and behavior symptoms. The 6/27/16 and 1/11/16 MDS indicated the resident required extensive assistance of one person for walking in her room and in the corridor. The resident was coded as not steady and only being able to stabilize with staff assistance for: balance from seated to standing, walking, turning around facing opposite direction, and moving off the toilet. The resident was coded as using both a walker and wheelchair for mobility.

R33 was interviewed on 8/24/16 at 9:35 a.m. and stated, "I don't get the walking I want." The resident stated it was very important to her to walk more in order to increase strength and improve her ability to walk. She stated her goal was to be able to walk with a walker rather than being dependent on a wheel chair for mobility. R33 reported she was walked between 3 to 5 times a week by the Restorative Aide. R33 stated, "Not very often do I get to walk to the dining room and especially on the weekends. I would like to walk more with the Certified Nursing Assistants (CNAs.)" The resident stated, "I feel I sit too much." The resident reported she had not used a wheelchair for mobility prior to her admission to the facility about a year and a half ago. The resident stated, "I was walking with a walker and was not in a wheelchair. They (facility) said come here for therapy due to my weakness and I got put in a wheelchair and that is what happened. I did therapy till I reached my goal. They said I reached the goal." The resident stated, "They say they are working on it (implementing a more frequent walking program)." The resident stated she expressed her complaint about wanting to walk more with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 16	F 280		

staff in her care plan meeting and to a number of staff including the Restorative Aide, the Charge Nurse, the Director of Nursing (DON) and to the Social Service Designee (SSD), but she did not know what the outcome of her complaint.

Record review confirmed the resident's desire to walk more. According to a 7/7/16, "Plan of Care" note, "(R33) also stated that she wants to walk to meals and that staff should know that she wants to walk more."

Review of the "Functional Maintenance Program (FMP)" goal, dated 3/24/15, indicated the resident would be walked once a day, 3-5 days per week, occurring Monday through Friday. The "FMP Flow Sheet" records for July 2016 documented the resident walked with the Rehabilitation Aide a total of 17 times, meeting the FMP plan of 3-5 times a week. The "FMP Flow Sheet" records for August 2016 (through 8/24/16) documented the resident walking with the Rehabilitation Aide a total of 15 times, meeting the FMP plan of 3-5 times a week.

Interview with Rehabilitation Aide on 8/24/15 at 10:15 a.m. revealed the resident was on a Functional Maintenance Program (FMP) 3-5 days a week. The Rehabilitation Aide stated, "She (R33) is interested and has expressed to me that she wants to walk more (than what was provided in the FMP). We visited a couple weeks ago about that. She has maintained her level. Not losing ground is a good thing. Walking is difficult for her. She is not steady and needs assist of one. CNAs could walk her. I tell (R33) to ask the girls (CNAs) to walk her to lunch." The Rehabilitation Aide stated she was the only staff member who provided restorative services to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

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F 280	Continued From page 17	F 280		

residents and that she did not have enough time to routinely walk the resident to and from meals in addition to the walking provided 3-5 times a week. However, she stated the CNAs could be walking the resident to and from meals. The Rehabilitation Aide stated there was no formal walk to dine program in place.

On 8/25/16 at 1:23 p.m., the Charge Nurse was interviewed and stated the resident had discussed with her the desire to have more opportunities to walk. The Charge Nurse stated it was discussed at the resident's care conference on 7/7/16. The Charge Nurse stated she told the direct caregivers about the resident's wish (only verbal, face-to-face communication), but walking opportunities were not scheduled or planned. The Charge Nurse stated, "She (resident) can walk everyday if she wants. I encouraged her to ask if no one shows up to her room."

CNA3 and CNA4, who were care givers for the resident, were interviewed on 8/25/16 at 10:46 a.m. Both CNAs reported the resident did not walk independently and required staff assistance to walk. The CNAs reported the resident used her walker in her bedroom, with their assistance and use of a gait belt, to go to the toilet. The CNAs reported the only additional walking the resident did, was done with the restorative staff. They reported the restorative staff was responsible for walking the resident to meals. When asked whether they walked the resident to meals, they reported they did not.

The resident was not observed walking to and from meals with CNAs during the survey in accordance with her desire and the informal plan as stated in staff interviews noted above. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 18	F 280		

Continued From page 18

resident was observed to travel back and forth to meals and to move within her room independently, using a wheelchair throughout the survey.

On 8/22/16, between 5:20 p.m. and 6:00 p.m., the resident was observed to wheel herself to the dining room for the evening meal, eat her meal, and wheel herself back to her room following the evening meal.

On 8/24/16 at 9:35 a.m., the resident wheeled herself from the dining room back to her room following the breakfast meal.

On 8/25/16 at 11:59 a.m. the resident was observed to wheel herself back to her room after eating the noon meal.

The following problem was identified on the resident's care plan (July 2016): "Self-care deficit r/t (related to) osteoarthritis and general debility. Fluctuations may occur between limited and extensive assistance, depending on arthritis symptoms on a given day." The care plan goal, "Will continue to ambulate with assistance from staff, through next review." Care plan interventions included: extensive assist of 1 staff for ambulation with use of gait belt and FWW (front wheeled walker); functional maintenance program 3-5 times a week with rehab aide, and uses wheelchair as the main source of mobility.

Although the resident expressed her desire to walk more than 3-5 times a week in her care plan meeting in July 2016, to improve in her ability to walk using the front wheeled walker, and desire to walk to meals with the CNAs, the care plan was not revised. The care plan did not include the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 280		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 1 of 28 Stage 2 sampled residents (R9) was provided with nutritional interventions to address a history of unplanned weight loss. The facility failed to implement the physician prescribed Nutrition Intervention Program (NIP) and serve the resident a sufficient and balanced diet during the survey. Findings include: R9 was admitted to the facility on 3/11/11. According to a 7/6/16, "Physician Progress Note", the resident's current diagnoses included: dementia, anxiety, depression and	F 325	F325 Policy and Procedure addressing residents at nutritional risk were reviewed and updated to assure they are served a sufficient and balanced diet. Food will be stressed as the first option as intervention before supplements are offered. This policy will include the specifics of using nutritional supplement as a meal replacement with the guideline of being given when < 50% of meal is eaten and with the procedure of % of supplement taken being documented by LPN's/TMA's in the MAR. All Nursing staff were trained on when to offer nutritional supplements as a meal replacement and how/when to	9/20/16

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F 325	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 Review of a "Physician Progress Note" dated 7/6/16, indicated the resident was treated with Levaquin (antibiotic) for an upper respiratory infection and the resident being at risk for dehydration. Staff were to encourage fluid intake.	F 325	record percentage taken by resident. Dietary staff were in-serviced on the above policy and procedure on Tuesday, September 20th, 2016. Emphasis was placed on the need for all staff to follow up with any resident that is not eating the meal they have received to offer alternatives, encourage intake, and offer assistance if needed. NIP (Nutritional Intervention Program)Policy and Procedure reviewed and updated. NIP program includes, but is not limited to: adding 1/2 & 1/2; extra butter and/or gravy; brown sugar; ice cream; extra desserts; whole milk for any resident with unplanned weight loss. NIP tracking tool implemented 8/29/16 in order to track which interventions from the NIP diet are provided to each resident. These interventions will be monitored by the Dietary Mgr and adjusted when not effective with the consultant Dietitian involved in the process.(attachment) Dietary staff were in-serviced on the NIP diet and use of tracking tool on Tuesday Sept 20 by the Consultant Dietitian. R9 has been re-assessed to assure that nutritional interventions in place, including NIP diet features, are meeting resident's preferences and nutritional needs to assure acceptable parameters of nutritional status are maintained. All other residents at nutritional risk that are receiving the NIP diet have been re-assessed to assure that nutritional interventions, including the NIP diet features, are meeting each resident's preferences and nutritional needs to assure that acceptable parameters of	

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	245569	A. BUILDING ______ B. WING ______	08/26/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 21 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%. In addition to the longstanding order for nutritional supplement 4 ounces twice daily, on 7/26/16, the Physician prescribed 4 ounces of nutritional supplement to be used as a meal replacement when the resident refused her meals. On 7/26/16, the Dietitian wrote a "Nutrition/Dietary" note which indicated the resident's ideal body weight range was 108-132 pounds with the resident having a healthy body mass index of 20.75 (18.5 - 24.9 normal range according to "Pocket Resource for Nutrition Assessment", 2013, Academy of Nutrition and Dietetics, L. Eckstein, K. Adams, pg. 30). The resident's weight was documented as 124 pounds. The resident received a regular diet with 4 ounces of supplement twice daily and as a meal replacement. The resident's recent nutritional labs were within normal limits, except for a low	F 325	nutritional status are maintained. Dietary staff have been alerted to the need to offer vegetables to residents who select the basket meal option. This was also covered during the Dietary in-service on Tuesday Sept 20 by the Consultant Dietitian. CDM/Consultant Dietitian/Designee will visually audit 3x/wk for 4 weeks, then weekly x 4 weeks, then randomly thereafter to maintain/sustain compliance. All audits will be brought to QA by CDM and/or Consultant Dietitian for review and further recommendations for 6months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

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HALSTAD LIVING CENTER	133 FOURTH AVENUE EAST HALSTAD, MN 56548

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F 325	Continued From page 22	F 325		

BUN. The resident received vitamin supplements and had a recent change from Prilosec (heartburn medication) to Pepcid (heartburn medication). The Dietitian's new recommendation on 7/26/16 was for implementation of the NIP.

A 7/28/16 "Plan of Care" note indicated the resident was legally blind but able to feed self following orientation to type and placement of food. Set up was provided as needed. The resident had a recent respiratory infection, and although symptoms had improved, she had not returned to her prior level of functioning.

The July 2016 "Care Plan" documented the problem of "Resident with inadequate calorie intake r/t (related to) refusing meals on frequent basis e/b (evidenced by) slight, but steady declines in weight." The care plan goal documented, "Goal weight of 120-135# (pounds)." Interventions were: "Regular diet. NIP diet for extra calories at meals. Encourage intake of food/fluids. Trial meals in room to see if resident's intake improves. Lipped plate. 4 oz (ounces) nutritional supplement bid (twice a day). Nutritional supplement as meal replacement. Vitamin supplements per MD (Medical Doctor) order. Water pitcher at bedside."

The "Nutritional Intervention Program (NIP) Diet" policy and procedure (undated) indicated residents with actual or potential significant weight loss would receive appropriate interventions to encourage weight gain. The policy read, "Real food options will be given first priority, with commercial nutritional supplements to follow." The NIP diet included a variety of options to increase calories at meals including: whole milk, half and half on cereal, syrup in hot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

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F 325	Continued From page 23	F 325		

cereal, brown sugar in hot cereal, where appropriate extra gravy, extra butter, smoothies made with ice cream, pudding, Jello, magic cup, and increased portions, especially of specific food favorites of the resident.

Observations during the survey revealed a failure to implement interventions from the NIP and a failure to serve the resident an adequate, balanced diet:

-Evening Meal on 8/22/16
Meal observations were conducted from 5:01 p.m. through 5:50 p.m. R9 was served an oval fast food type basket with a paper lining, which contained a corn dog and fries. The resident was served the dessert according to the menu, which was pistachio pudding. R9 was not served a vegetable; creamy cucumbers were the designated vegetable and a tomato slice were served to residents that did not receive meal baskets. The resident was not served any of the interventions from the NIP at this meal (for example: whole milk, gravy, butter, or increased portions.)

-Breakfast on 8/24/16
At 8:15 a.m., the resident was observed in the dining room sitting at the dining room table. The resident had both water and coffee at the table and was drinking coffee. The resident was not served any other beverages (milk and juice were available and on the menu). The resident was served one piece of toast with a slice of American cheese on top and 1piece of bacon. The resident was not served any other foods. The resident ate ½ of the piece of toast and drank ½ of the cup of coffee only. She ate none of the bacon. The resident was observed wheeling herself out of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

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HALSTAD LIVING CENTER	133 FOURTH AVENUE EAST, HALSTAD, MN 56548

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F 325	Continued From page 24 dining room at 8:35 a.m. The resident received no cueing or encouragement to eat during the meal. The resident was not offered anything else to eat. The resident was not served an adequate meal; the menu called for oatmeal, egg of choice, toast, and cold cereal (menu called for oatmeal and cold cereal) milk/juice/coffee/tea. The resident was not served any of the interventions from the NIP (for example: whole milk, half and half, syrup or brown sugar on hot cereal, extra butter, or increased portions.) -Dinner on 8/24/16 The resident was sitting at the dining room table waiting for her meal at 11:41 a.m. The resident had coffee and water for beverages; she was not served any other beverages (milk and juice were available). The resident was served a food basket at 11:42 a.m., which consisted of a hot dog in a bun and waffle fries, and watermelon which was the dessert per the menu. The resident was not served a vegetable; the vegetable on the menu and available on the tray line was corn. The resident ate a few of the waffle fries. At 12:04 p.m. the resident wheeled herself away from the table. A staff member assisted her back to the table and asked her if she wanted more to eat. The resident remained at the table a few more minutes and then left. She ate a total of 50% of the waffle fries and none of the hot dog. She drank 50% of her coffee. The resident was not served any of the interventions from the NIP (for example: whole milk, gravy, butter, or increased portions.) -Dinner on 8/25/16 At 11:33 a.m. the resident wheeled herself into the dining room. The resident was served the regular diet according to the menu: Salisbury	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

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F 325	Continued From page 25 steak with gravy, green beans and mashed potatoes with gravy. She was served Jello with whipped topping for dessert. The resident was served coffee and water for beverages (milk and juice were available). The resident ate a few bites of the Jello and 75% of the meat with gravy and green beans. The resident did not eat the any of the mashed potatoes with gravy. The resident drank all her coffee and half of her water. At 12:05 p.m. the resident wheeled herself away from the table. A nurse approached the table and noted how much the resident ate and asked her if she wanted a push in her wheelchair. The resident was not cued to eat more. On 8/22/16 at 3:10 p.m., the Cook (Employee 1/ E1) was interviewed. She stated she had been employed in the facility for approximately 2 years and she cooked on day shift both breakfast and dinner meals. E1 stated residents had a choice for the regular entrée, alternate entrée or a food basket for the dinner and supper meals. The food basket consisted of a fast food sandwich such as a hot dog, hamburger or chicken patty and French fries. E1 stated residents were asked if they wanted the regular, alternate or a basket at the end of the previous meal and it was recorded so dietary staff knew what to prepare and serve. On 8/24/16 at 7:20 a.m. E1 was interviewed a second time prior to the breakfast meal. E1 was asked about the NIP designation that was written on 7 tray cards that were stacked on a tray. E1 stated, "It has to do with thickened. I am not sure." Later when the Dietary Manager (DM) arrived at 7:45 a.m., E1 and the DM explained that NIP stood for extra calories being added such as butter half and half on cereal. A Dietary Aide, E3, was interviewed on 8/26/16 at	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

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F 325	Continued From page 26	F 325		

7:23 a.m. E3 was responsible for serving beverages to residents and wheeled a cart with multiple beverages (such as milk, juice, coffee) from table to table. E3 stated she gave residents the beverages they wanted. When asked about who received half and half for breakfast, she reported it was served to the residents on pureed diets and to 2 other residents; R9 was not one of the residents who received half and half, a component of the NIP.

The DM was interviewed on 8/26/16 at 11:55 a.m. and was informed of E3's response about which residents received half and half for breakfast. The DM stated there was a posted list of residents on the NIP and E3 should be following the list and serving half and half to those residents. The DM verified that when residents received food baskets for dinner and supper, a vegetable was not customarily served, but stated it could be. In regards to R9, the DM stated if R9 ate less than 50%, she was served a supplement by the medication nurse after the meal. The DM stated meal intake was recorded for residents prior to MDS due dates. R9's meal percentage was not on the current list. The DM stated R9 should be served foods from the NIP program as the foods fit in with her food choices. The DM did not know exactly which foods the resident was receiving for the NIP. There was no specific plan for R9 regarding which foods she would be served from the NIP options. When asked about the small breakfast served to the resident on 8/24/16, the DM stated residents were asked at the breakfast meal what they wanted and were served according to their request. When asked about small meals (breakfast on 8/24/16) and the absence of milk being served to R9, the DM reported the resident did not always eat much

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

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F 325	Continued From page 27	F 325		

and the supplement meal replacement was in place to address that.

The Medication Administration Record (MAR) was reviewed to determine how often and how much supplement the resident consumed as a meal replacement. The August 2016 MAR entry read, "Give nutritional supplement as meal replacement when meal is refused 8 am % eaten 12 pm % eaten 6 pm % eaten." The MAR had boxes for documenting all 3 meals (8 a.m., 12 p.m., and 6 p.m.) and boxes for documenting percentage eaten for all 3 meals. In the boxes for times, nurses' initials were documented and in the boxes for percentage eaten a percent amount was recorded. It was unclear when the supplement was given and if the percentage reflected the meal percentage or percentage of the supplement consumed.

On 8/25/16 at 2:02 p.m., the Charge Nurse was interviewed and stated she was unsure whether the initials meant R9's supplement was given, or only that the % eaten of the meal had been monitored but the supplement was not needed.

On 8/25/16 at 2:06 p.m., Licensed Practical Nurse (LPN 1) was interviewed and stated she gave the supplement every time it was initialed; she thought it was best to give the resident the supplement whenever she would accept it.

CNA 3 was interviewed on 8/25/16 at 10:45 a.m. and stated R9 fed herself, but staff had to tell the resident where the food was on her plate as she had poor vision. When asked about offering snacks to the resident between meals, she stated the resident's husband had candy bars in their room and R9 snacked on these. She stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	133 FOURTH AVENUE EAST HALSTAD, MN 56548

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F 325	Continued From page 28 was not aware of any snacks being sent from the dietary department for R9. The Dietitian was interviewed on 8/25/16 at 3:08 p.m. and reported the resident had a significant change the end of July 2016 with some weight loss, but was still within her ideal body weight. The Dietitian stated the NIP was initiated in response to the resident's weight loss. When asked about which interventions the resident received from the NIP, she stated she would have to ask the DM. The Dietitian verified there was no specific plan or any documentation regarding which foods from the NIP the resident would be offered and/or which ones she would accept. When asked about the supplement used as a meal replacement and the documentation that was unclear, she stated, "I would want to know if she is getting the supplement."	F 325		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to ensure menus were nutritionally adequate and followed for all 4 of 28 residents in the Stage 2 sample (R38, R18, R13, R37) who were prescribed pureed diets and for 8 of 28 residents	F 363	F363 Dietary staff were in-serviced on Tuesday September 20th, 2016 and reviewed diet extensions, how to read them and use them, and to stress the importance of following them to assure appropriate	9/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

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HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

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F 363	Continued From page 29 in the Stage 2 sample (R9, R16, R7, R48, R21, R19, R4) who were served meal baskets during the survey. Two of 28 Stage 2 sampled residents (R33, R36) complained the menu lacked variety and was not adequate. Findings include: 1.The menu was not followed for all 4 residents prescribed pureed diets (R38, R18, R13, R37). a. On 8/22/16 the menu directed staff to serve pureed green beans as the vegetable for the supper meal. The menu directed residents on regular diets to be served creamy cucumbers. Meal observations were made between 5:01 p.m. and 5:50 p.m. All 4 residents on pureed diets were observed to receive pureed cucumbers and pureed tomatoes instead of pureed green beans. Cucumbers and raw tomatoes have seeds and are not recommended to be pureed and served to residents on pureed diets. Foods on pureed diets should be homogeneous, cohesive and pudding like in texture (American Dietetic Association. Level 1 pureed diet: patient handout. In Nutrition Care Manual. www.nutritionacaremanual.org <http://www.nutritionacaremanual.org>. Accessed January 10, 2011.) b. On 8/24/16 the menu directed staff to serve whipped squash as the vegetable for the dinner meal to residents on pureed diets. The menu directed residents on regular diets to be served buttered corn. Meal observations were made between 11:00 a.m. and 11:55 a.m. All 4 residents on pureed diets were observed to be served pureed corn instead of whipped squash per the menu.	F 363	foods for mechanically altered diets are provided for those residents requiring such diets. In-servicing was completed by the Consultant Dietician. Consultant Dietician and/or Dietary Mgr, will also be responsible for nutritional analysis for all resident's who reside here. Use of the menu substitution log was reviewed on Tuesday September 20th, 2016 in-service with emphasis given to following the diet extensions. Only when a food is unavailable will a substitution be made. In this case the substitution will be documented and explained on the menu substitution log and posted on the menu board. It was stressed that vegetables designated for Pureed diets be followed as noted on the diet extensions to ensure that R38, R18, R13, R37, are provided appropriate and safe vegetables. Two vegetable choices will be offered when a resident chooses the basket meal alternate. A resident's right to refuse vegetable offerings will be honored, as it is when the main menu is chosen. The 7 residents who chose meal baskets during survey observation, R9, R16, R7, R48, R21, R19, R4 as well as, any other resident who chooses the basket meal will be offered two vegetable choices and will be encouraged to enjoy a vegetable. A fourth week will be added to the current seasonal menu cycles. The current menu cycles will be reviewed and updated with foods that are not as popular with residents being switched out for new items. A discussion will be held with the Dietary Mgr, Consultant Dietician, and Administrator about whether it is wise to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 363	Continued From page 30	F 363		

The menu also directed residents on pureed diets to be served pureed watermelon. The menu directed residents on regular diets to be served watermelon. All 4 residents on pureed diets received pureed pineapple instead of pureed watermelon.

c. The Dietary Manager (DM) was interviewed at 11:55 a.m. The surveyor showed her the menu and asked about the squash that was on the menu. The DM looked at the menu and stated there was no squash and she was not aware it was on the menu instead of corn. The DM verified residents on pureed diets had been served pureed corn. The DM stated pureed pineapple was served in place of pureed watermelon; she did not explain why the substitution was made.

2. Residents who selected meal baskets were not served vegetables in accordance with the menu.
a. Residents had a choice of selecting the main entrée, alternate entrée or a meal basket for the dinner and supper meals. The meal basket choice for the supper meal on 8/22/16 consisted of a corn dog and fries. The vegetable according to the menu was creamy cucumbers. None of the 7 residents (R9, R16, R7, R48, R21, R19, R4) served meal baskets were served a vegetable; these residents were served corn dogs with fries.

b. R9 was sitting at the dining room table waiting for her meal on 8/24/16 at 11:41 a.m. The resident was served a food basket at 11:42 a.m., which consisted of a hot dog in a bun and waffle fries. The resident was not served a vegetable; the vegetable on the menu and available on the tray line was corn.

continue offering a basket meal at every lunch and supper. Also the possibility of adding a salad bar will be discussed as a way to increase fresh vegetables and fruits and providing a greater variety of foods at each dinner and supper.
The Dietary Mgr will attend Resident Council to receive input from residents regarding their wishes as far as changes they would like to see made to the menu. R33 and R36 will be specifically interviewed by the Dietary Mgr to obtain their input on menu revisions. R33's suggestions such as fewer sandwiches and more fresh fruits and vegetables will be considered for menu revision.
All four weeks of both seasonal cycles will be reviewed for menu adequacy. Once updated after resident input, a nutritional analysis will be completed for the most relevant macro and micro-nutrients. These analysis reports will be placed in the diet extension binders for each menu cycle.
All facility policy and procedure manuals will be reviewed by Dietary Mgr and/or Consultant Dietician to assure that the most current and up-to-date policies are in place and outdated policies are archived.
Dietary Mgr/Consultant Dietician will visually audit pureed diet meals of all residents who receive them for proper vegetable choice/options and for offering of a vegetable when residents choice is the basket meal. This will be done 3x/wk for 1mo, and then 1x/wk for 1 mo until 100% compliance is attained. Then randomly thereafter to ensure compliance is maintained for all residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _______ B. WING _______	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

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F 363	Continued From page 31 c. On 8/22/16 at 3:10 p.m., the Cook (Employee 1/ E1) was interviewed; she stated she had been employed in the facility for approximately 2 years and she cooked on day shift both breakfast and dinner meals. E1 stated residents had a choice for the regular entrée, alternate entrée or a food basket for the dinner and supper meals. The food basket consisted of a fast food sandwich such as a hot dog, hamburger or chicken patty and French fries. The DM was interviewed on 8/24/16 at 11:55 a.m. and verified that when residents ordered food baskets for dinner and supper, a vegetable was not customarily served, but stated it could be. 3. Two residents reported they tired of the menu and that menu was not adequate. a. R33 was interviewed on 8/22/16 at 5:00 p.m. and on 8/26/16 at 7:45 a.m. The resident reported she was not satisfied with the menu. R33 stated there were too many sandwiches, not enough fresh foods, as well as too many fried and breaded foods. R33 reported the portions and meals were inconsistent with small meals being served at times. On 8/26/16, the resident stated, "There are a lot of things on the menu I don't like - fried foods, heavy foods. They serve hamburgers and patty melts, but they are so greasy. The grilled cheese is greasy too. The menu repeats about every other week. There is not a lot of variety. I made some suggestions about food I like: salmon, soups, fresh salads, but they say it can't be done. The menu needs to change; you know what's coming and there's no variety." b. Resident 36 was interviewed on 8/23/16 at	F 363	Dietary Mgr and/or Consultant Dietician will bring audit results to QA committee for further review/suggestions for six months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	133 FOURTH AVENUE EAST HALSTAD, MN 56548

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F 363	Continued From page 32	F 363		

9:45 a.m. and stated the food was not always good and he got tired of being served the same foods. On 8/23/16 at approximately 12:05 p.m. R36 was leaving the dining room following the dinner meal. When asked how the meal was, he reported he had a hamburger, that it was not very good and he was tired of hamburgers.

c. Review of the menus showed a 3-week cycle menu was in place; the menu repeated itself every 3 weeks.

d. A nutritional analysis of the menu was requested from the DM on 8/24/16 at 7:50 a.m. The DM stated she had checked with the Dietitian and there was no nutritional analysis of the menu. The DM was interviewed on 8/26/16 at 8:00 a.m. and stated the menu used to be a 5-week cycle menu and had been shortened to a 3-week cycle menu with the introduction of the meal baskets. The DM stated the 3-week cycle menu was shorter with foods repeating more often. The DM stated the current menu ran through September and a winter/spring menu would then be started. The DM provided two conflicting policies related to meeting residents' nutritional needs. The DM did not know which policy was the current one.

e. One of the policies provided by the DM was undated; it was titled, "Policy: To meet the nutritional needs of our residents through the least restrictive means." The regular diet was documented as providing between 2000-2400 calories.

The second policy had a revision date of 4/05 with a review date of 12/12. The policy and procedure was titled, "(Facility) Policy and Procedure" for diets offered. The policy indicated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 363	Continued From page 33 "Calories: Each day's menu will provide approximately 1600-1800 calories. "Under portions sizes it read, "Overall portion sizes will follow what was once considered small portions. This is in response to the continued resident concern that too much food is provided. This change will address not only our residents with small appetites, but also should help with our resident who are overweight. Resident will be encouraged to ask for seconds and staff will be trained to offer more, especially to those resident at nutritional risk." e. The Dietitian was interviewed on 8/25/16 at 3:08 p.m.; she stated the undated policy that indicated between 2000-2400 calories would be provided daily through the menu was the current one in place. The Dietitian stated she wrote the menus; she verified no nutritional analysis had been completed and that the cycle menu was shortened from 5 to 3 weeks. The Dietitian stated she used general guidelines of 5-6 ounces of protein a day, 5 fruit and vegetable servings combined, and consistent carbohydrate. The Dietitian stated staff were to always offer vegetables at every noon and evening meal. The Dietitian stated when meal baskets were served; residents should be served the vegetables that were on the menu in addition to the meal basket.	F 363		
F 366 SS=E	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced	F 366		9/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 366	Continued From page 34 by: Based on observation, record review, and resident and staff interview, the facility failed to ensure alternates were offered to 5 of 28 residents in the Stage 2 sample (R33, R1, R22, R11, R9) when residents did not eat what was served. Findings include: 1. R9 was admitted to the facility on 3/11/11. According to a 7/6/16, "Physician Progress Note", the resident's current diagnoses included: dementia, anxiety, depression and gastro-esophageal reflux disease. On 8/24/16 at 8:15 a.m., the resident was observed sitting at the dining room table. The resident had both water and coffee at the table and was drinking coffee. The resident was served one piece of toast with a slice of American cheese on top and 1 piece of bacon. The resident ate none of the bacon, ate half of the piece of toast and drank half of the cup of coffee. R9 was not offered anything else to eat or drink. The resident was observed wheeling herself out of the dining room at 8:35 a.m. R9 was served only water and coffee at 3 of 3 meals observed for beverage service (breakfast 8/24/16, dinner 8/24/16, and dinner 8/25/16). The resident was not served milk or juice at during meals and she was not served alternates (during the meal or in between meals) to compensate for the milk exchange and the juice exchange. 2. R1 was admitted to the facility on 9/13/12. The "Admission Record" documented diagnoses including dementia, cerebrovascular disease,	F 366	F366 A policy and procedure to assure that substitutes are offered of similar nutritive value to residents who refuse food served will be written. Staff were in-serviced on this policy on Tuesday Sept 20th by the Consultant Dietitian. Staff were trained on the need to encourage intake and to offer alternates of similar nutritive value of foods a resident is not eating. Recipes were reviewed to assure adequate portions of food components are being served to residents. A listing of acceptable alternates for milk was created to assist staff in offering other high calcium foods to residents who don't drink milk (attached). R9 will be served alternate high calcium foods when she does not accept milk. Any resident who does not drink milk will be offered a high calcium food in place of milk. R9 will be served an alternate food option of similar nutritive value when she does not except juice. All other residents who consistently refuse juice will be offered an alternate food that is similar in nutritive value. Fruits such as pineapple tidbits, mandarin oranges, peaches, and pears or fresh citrus fruits will be available each day on the beverage cart so that staff can offer those to residents who do not accept juice. Lists will be posted in the dining room with alternate food sources fro milk; juice; vegetables; and protein available to all dietary staff and nursing staff. Planned alternate entrees and vegetables will be included on posting menus and diet	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	08/26/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 366 Continued From page 35

gastro esophageal reflux disease, and weakness. The resident's seat assignment was in the portion of the dining room designated for residents who needed meal assistance.

On 8/22/16 the supper meal was observed, beginning at 5:01 p.m. R1 was served a patty melt sandwich, a tomato slice, creamy cucumbers in a small bowl and pistachio pudding for dessert. The resident was observed to eat little during the meal. At 5:45 p.m. the resident had finished eating. R1 had not eaten any of the sandwich or pudding. The resident had eaten a few bites of the cucumbers. At this time, a staff member asked the resident how the meal was. The resident stated, "You can have it." The resident was not offered an alternate at this time or at any other time during the meal. She consumed less than 25%.

3. R11 was admitted to the facility on 6/26/14; the "Admission Record" documented diagnoses including dementia, depressive disorder and arthritis. The resident ' s seat assignment was in the portion of the dining room designated for residents who needed meal assistance.

On 8/22/16 the supper meal was observed, beginning at 5:01 p.m. R11 was served a half a chicken salad sandwich (thin layer of chicken salad between slices of bread), creamy cucumbers in a small bowl, a tomato slice and pistachio pudding for dessert. The resident was observed to eat a total of a quarter sandwich and a few bites of the cucumbers and pudding. At 5:47 p.m. the resident had finished eating and a nurse aide approached the resident and asked her if she was finished. Although the resident had eaten approximately a third of the small meal

F 366

extension forms for every dinner and supper for both menu cycles.
R1, R11, R22, and R33 will be offered alternate foods/meals when they are not eating their chosen meal. Staff were trained on the need to monitor intake of these residents, along with all others, and when it is seen a residents is not eating well at a meal, alternates will be offered with the residents needing to be asked. All 4 of these residents were visited by the CDM to obtain updated food preferences, as the resident is able to provide. The CDM and/or designee will observe at least 5 meals a week and document whether these 4 residents in particular, but other residents as well, have been offered alternates when not eating. The CDM and/or designee will complete this observation over a 2 week period and will report findings at the next QA meeting. A tool was created to track findings. All staff will be reminded that real food should be emphasized over supplements.
All staff in-serviced on the basic customer service value of offering alternate meal/foods when a meal is not being eaten. It was emphasized that those residents deemed at risk or needing assistance should be of focus every meal with cues and encouragement to eat and with the expedient offering of alternative meal/foods when not eating. R1, R11, R22, and R33 in particular will be encouraged and assured alternatives. These procedures will be implemented for all residents as it has the potential to affect any/all at any time.
An audit addressing the above areas will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

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F 366	Continued From page 36 served, the resident was not offered an alternate at any time during the meal or when she was asked at the end of the meal if she was finished by the nurse aide. 4. R22 was admitted to the facility on 1/28/16; the "Admission Record" documented diagnoses including dementia, breast cancer, and major depressive disorder. The resident received hospice services. The resident's seat assignment was in the portion of the dining room designated for residents who needed meal assistance. On 8/22/16 the supper meal was observed, beginning at 5:01 p.m. R22 was served a chicken salad sandwich (thin layer of chicken salad between 2 slices of bread), creamy cucumbers, a tomato slice, and pistachio pudding for dessert. The resident was observed during the meal to pick at the meal. At 5:45 p.m. the resident had finished eating. R22 had not eaten any of the chicken salad sandwich or pudding. The resident ate less than 25% of the meal. The resident was not offered an alternate at any time during the meal. 5. R33 was admitted to the facility on 1/30/15. Current diagnoses, from the 4/4/16 quarterly Minimum Data Set (MDS) assessment, included anemia, heart failure, and high blood pressure. Review of the quarterly Minimum Data Set (MDS) dated 6/27/16 and annual MDS dated 1/11/16 demonstrated the resident was cognitively intact with a Brief Interview for Mental Status (BIMs) score of 15 (score of 13-15 consistent with cognitively intact per the Resident Assessment Instrument). R33 was interviewed on 8/26/16 at 7:45 a.m. and	F 366	be completed by the Dietary Mgr and/or CDM twice a week for the next 6 months (attached). The CDM will report to the QA committee quarterly for 6 months with audit results and corrective actions taken and monitor for solutions that are sustainable	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST HALSTAD, MN 56548**

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F 366	Continued From page 37	F 366		

reported alternates were not offered to her if she did not eat what was served at the meals. R33 stated, "I have to ask for something else if I don't want to eat what they serve me. I hate to ask all the time, but they don't come around and offer."

6. CNA1 and CNA2 were interviewed together on 8/25/16 at 4:42 p.m. The CNAs were asked what they would do if a resident did not eat their meal. Both CNAs failed to say that they would offer an alternate food if the resident did not eat what was served. Their comments were as follows:
-CNA1 stated, "If the resident is dependent we encourage them to eat. If they won't eat, then we give them Boost (nutritional supplement)."
-CNA2 stated, "I would do the same thing (as CNA1). If the resident is dependent, we feed them as much we can, I will put in the extra effort. If they don't eat, we get Boost. We always need to get fluids in."

The Director of Nursing (DON) was interviewed on 8/26/16 at 7:40 a.m. and stated the CNAs should offer an alternate food if a resident did not eat their meal prior to offering a supplement, such as Boost.

The Dietary Manager (DM) was interviewed on 8/26/16 at 8:00 a.m. and verified alternates should be offered if residents had poor intake during meals. The DM verified that an alternate entrée was included on the menu for the dinner and supper meals, but an alternate starch and vegetable exchange were not always included on the menu. The DM stated the menus used to have 2 vegetables listed for every dinner and supper but a number had been removed when the menu was reduced from a 5-week cycle menu (repeats itself every 5 weeks) to a 3-week

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F 366	Continued From page 38	F 366		

cycle menu. The DM stated this occurred approximately a year ago when the facility purchased a deep fat fryer and rolled out the food baskets (hot dog, hamburger, chicken patty or other fast food type of sandwich, with fries, onion rings or potato chips) as another meal option for dinner and supper.

The Dietitian was interviewed on 8/25/16 at 3:08 p.m. and stated residents should be offered an alternate if they did not eat what was served. When asked if alternates were planned, for example included on the menu, she stated there was an alternate entrée on the menu and the fast food basket option was available every day for the dinner and supper meals. The Dietitian verified alternates were not always planned for the starch and vegetable exchanges.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245569	A. Building B. Wing	11/21/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0166 Reg. # 483.10(f)(2) LSC	Correction Completed 09/16/2016	ID Prefix F0248 Reg. # 483.15(f)(1) LSC	Correction Completed 09/16/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 09/16/2016
ID Prefix F0325 Reg. # 483.25(i) LSC	Correction Completed 09/16/2016	ID Prefix F0363 Reg. # 483.35(c) LSC	Correction Completed 09/16/2016	ID Prefix F0366 Reg. # 483.35(d)(4) LSC	Correction Completed 09/16/2016
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

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) GA/mm	DATE 12/05/2016	SIGNATURE OF SURVEYOR 32603	DATE 11/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
8/26/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KMB9
Facility ID: 00764

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245569**

2. STATE VENDOR OR MEDICAID NO. (L2) **075740300**

3. NAME AND ADDRESS OF FACILITY
(L3) **HALSTAD LIVING CENTER**
(L4) **133 FOURTH AVENUE EAST**
(L5) **HALSTAD, MN** (L6) **56548**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/04/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Tammy Williams, HFE NEII — Date: 09/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Mark Meath, Enforcement Specialist — Date: 09/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

> **Opportunity to Correct - 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)

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

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

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

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

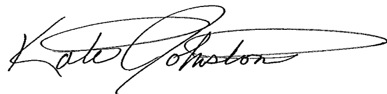
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

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

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,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were free from physical restraint for 1 of 3 residents (R22) reviewed for restraints. 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) and used a wheelchair for locomotion. The MDS did not identify R22 had a physical restraint during the 7	F 221	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's inability to propel her wheelchair when a brake is engaged. Staff were immediately counseled regarding the inappropriate use of wheelchair brakes and the risk to potentially restrain the resident. This alleged deficient practice has the potential to affect all residents that reside here. Staff will be re-educated on proper use of wheelchair brakes when a resident is able	9/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/26/2016

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.

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F 221 Continued From page 1

day assessment period.

Review of R22's current care plan dated 7/17/16, revealed R22 had severe cognitive impairment and required total assistance from facility staff for ADL's. R22's care plan revealed R22 used a tilt in 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.

Review of R22's progress notes form 2/4/16, to 7/29/16, revealed no documentation on use of a wheelchair restraint for R22.

On 8/3/16, R22 was continuously observed from 7:01 a.m. to 8:14 a.m. At 7:01 a.m. R22 was seated in a tilt in space chair. R22 was observed to have her eyes open and was looking around. R22's right wheelchair brake was locked. At 7:22 a.m. R22 remained seated in the tilt in space wheelchair with her eyes closed and her wheelchair brake locked. R22's right foot was on the floor and her left foot was on the wheelchair foot rest. At 7:28 a.m. R22 remained seated in the tilt in space chair near the nurses station with her eyes open. R22 placed her right foot on the footrest of the wheelchair, reached down with her right arm and grabbed hold of the right wheel of the wheelchair. R22 attempted to propel her wheelchair with her right arm and was unable to move forward as the wheelchair brake was locked. R22 placed both feet on the floor and began to repeatedly tap both feet on the floor. The director of nursing (DON) was observed to walk past R22 seated in the wheelchair, but did

F 221

to propel him/her self and when the resident is 'parked' on an uneven surface. Staff were reeducated to ask resident if they are ok with using a brake to keep them from rolling back on an uneven surface (such as the dining room)or to try turning the front small wheel of the chair slightly to attempt to stop the rolling, before applying the brake.
DON visually inspected all residents in wheelchairs who are able to propel themselves where the locking of a brake becomes a restraint.
Visual audits will be performed by DON/Designee 3x/wk for 1 month and then randomly thereafter to assure continued compliance. All staff were reeducated on or before 9/8/16 regarding the proper use of wheelchair brakes.
Restraint Policy and Procedures will be added to new employee orientation. The DON and/or designee will report findings of the audits to the QA Committee quarterly until 100% compliance is attained.

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F 221	Continued From page 2 not approach R22. Nursing assistant (NA)-A and registered nurse (RN)-A were observed to walk near R22 at the nurses station, but did not approach her or disengage the wheelchair brake. At 7:30 a.m. R22 remained seated in the tilt in space chair, with the right brake engaged. R22 reached down with her right hand to the wheelchair wheel and attempted to propel the wheelchair forward. R22 was unable to move her wheelchair. Rehab aid (RA)-A was observed near R22 in the wheelchair at that time, and did not provide assistance. At 7:31 a.m. RA-A stood behind R22, verbalized to the medication nurse she would move R22 back in her wheelchair. RA-A reached down and released the brake on R22's right wheel and assisted R22 in the wheelchair to her room. Upon entering R22's room, RA-A stated R22 needed to be scooted back into her tilt in space chair. RA-A then asked R22 to lean forward and used the back of R22's blue slacks to pull her buttocks towards the back of the chair. RA-A then adjusted R22's head rest and assisted R22 in her wheelchair back to the common area by the nurses station. RA-A did not lock R22's wheelchair brake. R22 remained in the tilt in space wheelchair propelling herself around the common area. On 8/3/16, at 7:36 a.m. RA-A stated it was usual practice to lock a brake on R22's chair depending on how she had been doing. RA-A stated R22 was able to propel herself in the tilt in space chair but at times could not and that's when R22's wheelchair brakes were locked for safety. At 8:05 a.m. R22 remained seated in the tilt in space wheelchair and propelled her wheelchair 2 doors down the 300 wing hallway. NA-A approached R22 and stated it was almost breakfast time. NA-A turned R22's wheelchair around and	F 221		

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F 221	Continued From page 3 brought R22 back to the common area by the nurses station where she stopped next to another residents wheelchair. NA-A then reached down and engaged R22's left wheelchair brake and immediately walked away from the area. At 8:10 a.m. RN-A walked over to R22 in the wheelchair, stood at R22's left side and spoke with her about the upcoming breakfast meal. RN-A proceeded to walk away from R22, had not disengaged R22's left wheelchair brake. At 8:13 a.m. licensed practical nurse (LPN)-A approached R22 in her wheelchair and administered medications to R22. LPN-A attempted to move R22's wheelchair forward, and was unable to move the wheelchair with the brake engaged. LPN-A disengaged the brake and moved R22 toward the dining room. NA-A took R22 to the dining room, and brought her to the table. NA-A reached down and engaged R22's right brake. R22 remained seated in her tilt in space wheelchair at the table from 8:14 a.m. to 8:54 a.m. to eat breakfast. R22's wheelchair brake remained engaged/locked during the entire breakfast meal. On 8/3/16, at 8:16 a.m. LPN-A stated R22 could propel herself in the tilt in space chair and could not recall unlocking R22's wheelchair brake. LPN-A stated R22's wheelchair brakes should not be locked as she could "meander" around. LPN-A stated R22 needed assistance to reach destinations, but could wheel herself a fair distance. At 8:54 a.m. NA-A approached R22, disengaged her right brake and assisted R22 out of the dining room into the common area by the nurses station. NA-A did not engage/ lock R22's wheelchair brake. Activity aid (AA)-A approached R22 and offered an opportunity to fold towels. After R22 agreed, AA-A assisted R22 out of the common area into the activity room.	F 221		

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F 221	Continued From page 4	F 221		

On 8/3/16, at 8:22 a.m. RN-A confirmed R22 was able to propel her wheelchair independently at times. RN-A stated engaging the brakes on R22's wheelchair would be considered a restraint. RN-A also stated R22 did not have a physician's order for the use of a restraint. RN-A confirmed R22's current 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 for R22. The DON stated she would expect staff to 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 was locking resident wheelchair brakes. She indicated she had questioned staff about why they were locking brakes and the DON believed this practice had become habit with some staff.

On 8/3/16, at 9:25 a.m. NA-A stated she would routinely lock R22's brake so R22 did not roll away. NA-A stated R22 had not rolled away before, but felt as a safety measure she would lock R22's brake. NA-A stated R22 could propel herself in her wheelchair but would not be able to go to a specific destination due to cognitive impairment. NA-A stated locking R22's wheelchair brake would prevent her from independently propelling herself. NA-A stated she locked the brake out of habit.

A facility policy and procedure titled, Physical Restraint, revised 5/09, identified the definition of a physical restraint was any manual method or physical or mechanical device, material or

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F 221	Continued From page 5 equipment which would restrict an individuals freedom of movement or access to ones body. The policy directed staff physical restraints were only to be used when ordered or in a medical emergency.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified experience with the utilization of a catheter for 1 of 1 residents (R31)reviewed with a catheter. Findings include: R31's quarterly Minimum Data Set (MDS) dated 5/23/16, identified R31 had moderate cognitive impairment, required extensive assistance with all activities of daily living (ADLs) and had upper and lower extremetity impairment. The MDS also identified R31 was always incontinent of bowel and bladder. R31's care plan dated 7/7/16, identified R31 had an indwelling catheter placed 7/5/16, for an inability to void for extended periods of time. Staff was to monitor for odorous urine, change the Foley catheter monthly and the Foley bag every 2 weeks. The care plan failed to identify additional catheter cares for cleaning or irrigating the	F 241	It is the policy of Halstad Living Center that the facility shall promote care for residents in a matter and in an environment that maintains or enhances each resident's dignity and individuality. R31 had an indwelling catheter placed on 7/5/16 due to urinary retention. It was noted by surveyors a strong urine odor in R31's bedroom and bathroom. R31's catheter bag will be changed weekly and the catheter bag will be cleaned daily with a solution of one part white vinegar and three parts water to control the urine odor per facility policy. This tx will be completed by the LPN on duty. R31's room has been thoroughly striped and cleaned by Environmental Service staff, including the walls, floors, baseboards, furniture, bed, bathroom and curtains which has eliminated the odor. Environmental Service staff will continue to clean R31's room daily. This deficient	9/8/16

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F 241

Continued From page 6
catheter.

On 8/1/16, at 5:00 p.m. R31 was in his wheelchair in his room in front of the TV. R31 had a catheter bag contained in a cloth bag on the side of his wheelchair. R31's bedroom had a strong, foul, concentrated urine odor.

On 8/3/16, at 7:15 a.m. R31 was observed in bed asleep with the catheter collection bag inside a cloth bag which sat on the floor next to his bed. A small silver pitcher to measure urine output and and empty urinal were on the back of R31's toilet. R31's bedroom and bathroom continued to have a strong, foul, concentrated urine odor.

On 8/3/16, at 8:26 a.m. registered nurse (RN-B) stated R31 required extensive assistance with all activities of daily living (ADLs) and was not a good decision maker. She stated she was aware of R31's urine odor and stated the urine odor started soon after R31's catheter was placed. She stated she felt there was sediment in the tube that could be causing the odor and the catheter should be gone through to check what was causing the urine odor. She stated R31's 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

F 241

practice has the potential to affect any/all residents with indwelling catheters. All staff reeducated on or before 9/8/16 on proper care of indwelling catheters per facility policies and procedures.
DON/Designee checked rooms of all residents with catheters for any odor and proper cleaning of catheter bags and urine collection cylinders. Proper catheter care will be added to new employee orientation.
DON/Designee will visually inspect/smell all residents rooms who have indwelling catheters 3x/wk for 1 month and then randomly thereafter for continued compliance. Results of audit will be reviewed by the QA committee for review/suggestions until 100% compliance attained.

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F 241	Continued From page 7 time nursing changed the catheter bag was on 7/20/16. On 8/3/16, at 10:54 a.m. trained medication assistant (TMA)-B stated R31 was not a good decision maker as his cognition wasn't good. She stated R31 was totally dependent on staff for cares. TMA-B stated R31's urine was dark and had an odor because he didn't drink enough. She stated his urine in the bag is dark and the odor started with the initiation of the catheter. She stated when she noticed the odor the nurses would have to change it. TMA-B stated she didn't know if she told the nurse about R31's odor before today. She stated all catheters had an odor. She stated she washed R31's perineal area with soap and water, emptied R31's foley bag and confirmed she didn't rinse out the bag but closed it back up. On 8/3/16, at 11:28 a.m. during a follow-up interview RN-B stated NA's open the catheter bag, emptied the bag and closed the bag and washed surrounding skin with soap and water. She confirmed NA's didn't rinse out the bag after it was emptied. She stated the LPN was responsible for irrigating with vinegar during the evening or night shift. RN-B stated she didn't know where the odor was coming from and stated the odor hung in the bag and in the tubing. She stated when she noticed the odor the other day it was really bad and she should have changed his catheter at that time. She stated she talked to the night nurse the other night and had her to irrigate the tubing with plain water and stated she felt it helped. On 8/3/16, at 11:48 a.m. NA-D stated she noticed R31's urine odor today and shelly told the nurse.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 8	F 241		

She stated she washed R31's perineal area with soap and water and emptied the catheter bag. She confirmed she didn't rinse the bag after she emptied it. She stated R31 was confused and totally dependent on staff for cares. She stated she agreed with Shelly and she felt all catheters had the same odor.

On 8/3/16, at 12:25 p.m. RN-B confirmed strong urine odor in R31's bedroom and bathroom. RN confirmed the urine odor in the bathroom was from the pitcher and urinal on the back of R31's toilet which were used to measure urine from R31's catheter bag. RN lifted R31's catheter bag from the cloth bag on the floor that contained 120 cc of light brown urine and confirmed the strong urine odor was from R31's catheter bag. She stated she felt R31's urine looked pretty good as there were no "chunks in it". She stated the NA's don't rinse the bag after emptying which would have caused more odor. She stated they could have rinsed the bag after emptying, used a leg bag, and rinsed the bag every day with vinegar, used 2 different bags alternating, or try odor control drops or efferdent tablets in the bag to control R31's urine odor.

On 8/3/16, at 1:10 p.m. DON stated R31 was 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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 9 for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the plan of care for 1 of 1 residents (R31) reviewed with a catheter. Findings include: R31's quarterly Minimum Data Set (MDS) dated	F 280	It is the policy of Halstad Living Center to complete a comprehensive care plan within seven days after completion of the comprehensive assessment; prepared by the IDT that includes the attending physician, a registered nurse, and other appropriate staff in disciplines as determined by each residents needs, and	9/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING _____ B. WING _____	08/04/2016

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F 280

Continued From page 10

5/23/16, identified R31 had moderate cognitive impairment, required extensive assistance with all activities of daily living (ADLs) and had upper and lower extremetity impairment. The MDS also identified R31 was always incontinent of bowel and bladder.

R31's care plan dated 7/7/16, identified R31 had an indwelling catheter placed 7/5/16, for an inability to void for extended periods of time. Staff was to monitor for odorous urine, change the Foley catheter monthly and the Foley bag every 2 weeks. Although facility staff was aware of odor and identified multiple interventions they could attempt, the care plan failed to identify additional catheter cares for minimizing the urine odor for R31.

On 8/1/16, at 5:00 p.m. R31 was in his wheelchair in his room in front of the TV. R31 had a catheter bag contained in a cloth bag on the side of his wheelchair. R31's bedroom had a strong, foul, concentrated urine odor.

On 8/3/16, at 7:15 a.m. R31 was observed in bed asleep with the catheter collection bag inside a cloth bag which sat on the floor next to his bed. A small silver pitcher to measure urine output and and empty urinal were on the back of R31's toilet. R31's bedroom and bathroom continued to have a strong, foul, concentrated urine odor.

On 8/3/16, at 8:26 a.m. registered nurse (RN-B) stated she was aware of R31's urine odor and stated the urine odor started soon after R31's catheter was placed. She stated she felt there was sediment in the tube that could be causing the odor and the catheter should be gone through to check what was causing the urine odor. She

F 280

if practicable, the participation of the resident, family, or legal representative, and periodically reviewed and revised by a team of qualified persons with each assessment.
Corrective action taken for R31 was to immediately change the catheter bag on 8/3/16. Prior to survey exit, an audit was conducted to ensure appropriate interventions are care planned for R31.
This alleged deficient practice has the potential to affect any/all residents with indwelling catheters.
All staff will be in-serviced on following facility policy to report immediately to licensed nursing when, if any, future odor is noted for all residents with indwelling catheters. Also reeducated regarding rinsing out collection cup with water after each use, and emptying in the toilet.
Licensed staff reeducated regarding proper care of urine collection bag and a treatment of rinsing the bag with 1 part vinegar and 3 parts water, allowing the water to remain in the bag for a minimum of 15-30mins per facility policy. Staff in-servicing was completed on or before 9/8/16.
DON inspected all residents rooms that have indwelling catheters for odors and reviewed the individual care plans of those residents for proper care of catheters with interventions for catheter care and odors.
All staff reeducated on proper catheter care and resolving odors for any residents' that have a catheter. All nursing staff were in serviced on or before 9-8-16.
Proper catheter care will be added to all

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F 280	Continued From page 11 stated R31's 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. On 8/3/16, at 10:54 a.m. trained medication assistant (TMA)-B stated R31's urine in the bag is dark and the odor started with the initiation of the catheter. She stated when she noticed the odor the nurses would have to change it. TMA-B stated she didn't know if she told the nurse about R31's odor before today. She stated all catheters had an odor. She stated she washed R31's perineal area with soap and water, emptied R31's foley bag and confirmed she didn't rinse out the bag but closed it back up. On 8/3/16, at 11:28 a.m. during a follow-up interview RN-B stated NA's open the catheter bag, emptied the bag and closed the bag and washed surrounding skin with soap and water. She confirmed NA's didn't rinse out the bag after it was emptied. She stated the LPN was responsible for irrigating with vinegar during the evening or night shift. RN-B stated she didn't know where the odor was coming from and stated the odor hung in the bag and in the tubing. She stated when she noticed the odor the other	F 280	new nursing employee orientations. Corrective actions will be monitored to ensure alleged deficient practice does not recur: DON/Designee will audit all residents rooms with catheters for odor three times weekly for four weeks, then one time weekly for fours weeks, then randomly thereafter to maintain compliance. Any negative patterns will be presented to the QA Committee for review/recommendations.	

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F 280	Continued From page 12	F 280		

day it was really bad and she should have changed his catheter at that time. She stated she talked to the night nurse the other night and had her to irrigate the tubing with plain water and stated she felt it helped.

On 8/3/16, at 11:48 a.m. NA-D stated she noticed R31's urine odor today and she told the nurse. She stated she washed R31's perineal area with soap and water and emptied the catheter bag. She confirmed she didn't rinse the bag after she emptied it.

On 8/3/16, at 12:25 p.m. RN-B confirmed strong urine odor in R31's bedroom and bathroom. RN confirmed the urine odor in the bathroom was from the pitcher and urinal on the back of R31's toilet which were used to measure urine from R31's catheter bag. RN lifted R31's catheter bag from the cloth bag on the floor that contained 120 cc of light brown urine and confirmed the strong urine odor was from R31's catheter bag. She stated she felt R31's urine looked pretty good as there were no "chunks in it". She stated the NA's don't rinse the bag after emptying which would have caused more odor. She stated they could have rinsed the bag after emptying, used a leg bag, and rinsed the bag every day with vinegar, used 2 different bags alternating, or try odor control drops or efferdent tablets in the bag to control R31's urine odor.

On 8/3/16, at 1:10 p.m. the director of nursing (DON) 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 facility policy and procedure titled, Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 13 Planning, revised 4/04, revealed it was a policy of the facility to develop individualized care plans for residents which would address assessed needs and interventions in place based upon assessment.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 REQUIREMENT is not met as evidenced by: 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. 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 devices for chair and mattress surfaces. 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	F 282	F282 It is the policy of Halstad Living Center to develop individualized care plans based on assessed needs to prevent skin breakdown and provide care by qualified persons in accordance with each residents written plan of care. No negative outcomes were noted from alleged deficient practice. Corrective action taken for all residents having the potential to be affected: Residents with specific turning, repositioning, and toileting programs have been audited by DON prior to survey exit (8/4/16) and prior to date of compliance by the DON. Measures put into place to ensure the alleged deficient practice does not recur: All staff were re-educated by the DON on the policy and procedure of following the turning, repositioning, toileting program per individualized care plan for each	9/8/16

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F 282

Continued From page 14

pressure ulcer interventions in place included a pressure air relieving mattress to R22's bed and a pressure relieving pad to recliner. R22's care plan directed facility staff to assist R22 to turn and reposition at least every 2 hours and as needed with 2 staff assistance. Review of R22's current care plan revised 7/24/16, directed facilty staff to assist R22 with toileting at least every 2 hours and to check R22's incontinent brief every 2 hours for total bowel and bladder incontinence.

R22 remained seated in the same position from 6:45 a.m. to 9:20 a.m., a total of 2 hours and 35 minutes. On 8/3/16, during continuous observations 7:01 a.m. 9:20 a.m. R22 was not observed to be repositioned or checked/changed. R22 was observed to remain in her tilt in space wheelchair from 7:01 a.m. through 9:20 a.m. without offloading from her buttocks or offer/provision of toileting services.

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 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.

On 8/3/16, at 9:29 a.m. NA-C stated R22 required total assistance with repositioning and checking and changing at least every 2 hours.

On 8/3/16, at 10:40 a.m. during a follow up interview NA-A stated she had though R22's hospice aide had assisted R22 to reposition when he was there for cares that morning. NA-A stated when R22's hospice aide would come he was

F 282

resident needing such. This alleged deficient practice has the potential to affect all residents residing here. Staff will be re-educated regarding use of I-pads for reference to individualized care plan for each resident on or before 9-8-16. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: DON/Designee will conduct visual audits 3x/wk for 4 weeks, audits will continue 4x/month for 1 month, and then randomly thereafter until 100% compliance is maintained consistently. Any negative patterns will be reported to QA committee for further review/recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 15	F 282		

responsible for repositioning and checking and changing R22 and was not aware he had not done so.

On 8/3/16, at 10:51 a.m. RN-A confirmed the hospice NA note revealed no cares were provided to R22 by the hospice aid. RN-A stated R22 required assistance with repositioning, checking and changing at least every 2 hours. RN-A confirmed R22's care plan was current and directed staff to assist R22 with assessed repositioning and toileting needs.

On 8/3/16, at 10:59 a.m. the director of nursing (DON) stated she expected staff to follow R22's care plan for the assessed needs of repositioning and checking and changing at least every 2 hours.

Review of facility policy and procedure titled, Care Planning, revised 4/04, revealed it was a policy of the facilty to develop individualized care plans for residents which would address assessed needs and interventions in place based upon assessment.
R31's quarterly Minimum Data Set (MDS) dated 5/23/16, identified R31 was always incontinent of bowel and bladder and was at risk for developing pressure ulcers and had a pressure relieving device for his chair.

R31's care plan dated 7/7/15, identified R31 had the potential for alteration in skin integrity related to impaired physical mobility, impaired skin integrity, incontinence, poor safety awareness and multiple medical problems. The care plan also identified R31 required extensive assist of 2 staff to turn and reposition in bed and chair every 2 hours and as necessary.

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F 282	Continued From page 16	F 282		

R31's care area assessment (CAA) dated 12/7/15, identified R31 was at risk for developing pressure ulcers as R31 required extensive assistance with ADLs, was always incontinent of bowel and bladder and had weight loss.

The undated facility form titled Visual/Bedside Kardex Report which served as a nursing assistant care guide, directed staff to turn and reposition R31 every two hours when in bed and chair.

Continuous observation on 8/2/16, from 5:21 p.m. to 8:00 p.m. identified R31 had not been offered or repositioned in his chair. On 8/2/16, at 5:21 p.m. R31 was seated in the dining room at dining room table waiting for his evening meal. Resident's chair was in an upright position. At 5:47 p.m. licensed practical nurse (LPN)-B administered R31's medication. At 6:00 p.m. R31 was fed his meal by nursing assistant (NA)-H. At 6:29 p.m. NA-E tilted R31's wheelchair back slightly and wheeled him from the dining room to the day area. At 7:15 p.m. NA-G pulled R31's shirt down over his belly as his lower belly was exposed. NA-G stated out loud to herself, "I think we'll have to put him to bed soon, I'll have to check with my partner and see what she says." R31's head was hanging forward and to the left, off of the head rest. At 8:00 p.m., after surveyor intervention, R31 was laid down.

On 8/2/16, at 7:56 p.m. NA-G stated she was was assigned to R31's care for that evening. She stated she didn't know exactly when R31 was last repositioned, but stated it was sometime before supper. NA-G stated R31 was supposed to be repositioned every 2 hours when in his chair or

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F 282	Continued From page 17 bed. She confirmed she did not offer R31 repositioning. On 8/3/16, at 8:26 a.m. registered nurse (RN)-B confirmed R31's care plan and stated R31 should have been repositioned every 2 hours. She confirmed the reason for every 2 hour repositioning was to offload pressure and prevent skin breakdown. She confirmed R31 required extensive to total assistance from staff for repositioning. RN-B confirmed R31 would not be able to offload pressure from his bottom while in his chair without staff assistance. On 8/3/16, at 10:54 a.m. trained medication assistant (TMA)-B stated current interventions to keep R31's skin intact were to reposition R31 every 2 hours and use barrier cream on his bottom. She stated R31 should be repositioned every 2 hours. She stated R31 was totally dependent on staff for bed mobility and repositioning. She stated R31's care plan directed staff to turn and reposition R31 every 2 hours. On 8/3/16, at 11:48 a.m. NA-D stated R31's care plan directed them to reposition him every 2 hours to prevent open areas. On 8/3/16, at 1:10 p.m. the director of nurses (DON) stated R31 was at risk for developing pressure ulcers and required repositioning every 2 hours. The DON confirmed R31 required extensive assistance with repositioning and was totally dependent on staff for repositioning. She stated she would expect staff to follow the plan of care and reposition R31 every 2 hours to prevent the development of pressure ulcers. Review of facility policy and procedure titled,	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 18 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.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: 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. 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 frequently incontinent and was not on a toileting program. Review of R22's current care plan revised 7/24/16, directed facilty staff to assist R22 with toileting at least every 2 hours and to check R22's	F 312	F312 It is the policy of Halstad Living Center to provide ADL care to dependent residents who are unable to maintain necessary activities of daily living for grooming, nutrition, turning/repositioning, toileting and personal hygiene & oral hygiene independently. Corrective action taken for R22: Re educated staff on the importance of following the plan of care regarding turning, repositioning, incontinent care of dependent residents. DON/Designee visually monitored these areas for compliance for all residents who have the potential to be affected by the alleged deficient practice prior to and since survey exit on 8/4/16. No negative outcomes identified by the alleged deficient practice. Measures put into place to ensure the	9/8/16

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F 312	Continued From page 19 incontinent brief every 2 hours for total bowel and bladder incontinence. Review of a quarterly nursing assessment dated 7/24/16, identified R22 was frequently incontinent of bowel and bladder and required total assistance from staff with incontinence cares as directed by the care plan. R22 went 2 hours and 35 minutes without toileting. On 8/3/16, during continuous observations 7:01 a.m. 9:20 a.m. R22 was not observed to be toileted. On 8/3/16 at 9:25 a.m. nursing assistant (NA)-A stated R22 was up in the wheelchair at 6:45 a.m. On 8/3/16 at 7:01 a.m. R22 was seated in a tilt in space chair. At 7:28 a.m. R22 remained seated in a tilt in space chair near the nurses station. At 7:31 a.m. rehabilitation aide (RA)-A assisted R22 in the wheelchair to her room. Once in her room, R22 was boosted back in her wheelchair by RA-A. RA-A adjusted R22's head rest and assisted R22 in her wheelchair back to the common area by the nurses station. RA-A was not observed to check and/or change R22's incontinent brief. At 8:05 a.m. R22 remained seated in the tilt in space wheelchair. NA-A approached R22, stated to R22 that it was almost breakfast time. NA-A did not offer R22 assistance with toileting. At 8:13 a.m. licensed practical nurse (LPN)-A approached R22 and administered her medications. NA-A then took R22 to the dining room for breakfast. R22 was not offered assistance with repositioning or with checking and changing. R22 remained in the dining room until 8:54 a.m. NA-A then assisted R22 out of the dining room and back to the common area by the nurses station. Activity aid	F 312	alleged deficient practice does not recur: All staff were reeducated immediately by the DON on the policy and procedure of following the turning, repositioning, toileting program per individualized care plan for each resident. All staff will be re-inserviced regarding the use of I-pads for reference to individualized care plan for each resident on/before Sept 8th, 2016. Corrective actions will be monitored to ensure the alleged deficient practice will not recur: DON/Designee will conduct visual audits 3x/wk for 4 weeks. Audits will continue 4x/month for 1 month and then randomly thereafter until 100% compliance is maintained consistently. Any negative patterns will be reported to QA committee for further review/recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 20	F 312		

(AA)-A offered R22 to go fold towels in the activity room. R22 accepted and was provided a pile of towels for folding. At 9:04 a.m. R22 remained seated in her wheelchair in the activity room. No staff had been observed to offer repositioning or check and changing. At 9:16 a.m. NA-A entered the activity room. NA-A was not observed to approach R22 or offer assistance with cares. At 9:19 a.m. AA-A approached R22, she had folded all of the towels, and asked her if she wanted to go back to her room, R22 had replied yes. AA-A then 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 with the mechanical lift. NA-A removed R22's incontinent brief which was wet with urine on the back portion of the brief.

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 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.

On 8/3/16, at 9:29 a.m. NA-C stated R22 required total assistance with repositioning and checking and changing at least every 2 hours.

On 8/3/16, at 10:40 a.m. during a follow up interview NA-A stated she thought R22's hospice NA had assisted with repositioning when he was there for cares that morning. NA-A stated when R22's hospice aide was there, he was responsible for repositioning and checking and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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

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F 312	Continued From page 21 changing R22. NA-A and was not aware he had not done so. NA-A stated she would usually verbally communicate with the hospice aid on what was done for R22 though did not do it this time. On 8/3/16, at 10:51 a.m. RN-A stated the usual practice for residents who received hospice care was for the NA's to verbally communicate what cares were provided for R22 prior to the hospice NA leaving. RN-A stated the hospice NA note revealed no cares were provided to R22 by the hospice aid. RN-A stated R22 required assistance with repositioning, checking and changing at least every 2 hours. On 8/3/16, at 10:59 a.m. the director of nursing (DON) stated she expected staff to follow R22's care plan for her assessed need of repositioning and checking and changing at least every 2 hours. Review of a facility policy and procedure titled, bathroom/commode assisting, revised 11/03, revealed the policy directed facility staff that all residents were to be assisted with toileting needs per care plan.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		9/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ B. WING ______	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 22 prevent new sores from developing. This 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. 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 devices for chair and mattress surfaces. 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 pressure ulcer interventions in place included a pressure air relieving mattress to R22's bed and a pressure relieving pad to recliner. R22's care plan directed facility staff to assist R22 to turn and reposition at least every 2 hours and as needed with 2 staff assistance. Review of a tissue tolerance (TT), the ability of the skin and its supporting structures to endure the effects of pressure, without adverse effects,	F 314	F314 See F282 It is the policy of Halstad Living Center to ensure that a resident who enters the facility without a pressure sore, does not develop pressure sores unless the individual's condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. R22 continues to be at high risk for potential development of pressure ulcers and needs assistance with turning/repositioning. R22 does not currently have any open/reddened areas. No negative outcomes arose from the alleged deficient practice. Corrective action taken for all residents having the potential to be affected by the alleged deficient practice: Residents with specific turning/repositioning plans will be visually audited by the DON/Designee 3x/wk for 1mo and 1x/wk for another month, to ensure compliance is achieved and maintained. All staff will be re-educated regarding following the individualized POC for turning/repositioning each resident on or before September 8th, 2016. Any negative patterns will be reported to QA committee for further review/recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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

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F 314	Continued From page 23	F 314		

dated 7/26/16, identified R22's skin was intact and was able to tolerate every 2 hour repositioning.

Review of a skin wound note dated 4/24/16, revealed R22 continued to require assistance from staff for daily cares and needs. The note revealed R22 was at high risk for skin breakdown, was frequently incontinent of bowel and bladder and required staff assistance for needs.

Review of a skin wound note dated 6/21/16, revealed R22 had 3 stage I pressure ulcers (non-blanchable erythema of intact skin) on her coccyx which measured 0.75 centimeters (cm) x 0.75 cm. The note revealed a pressure relieving mattress was implemented to aid in healing.

Review of a skin wound note dated 7/1/16, revealed R22's pressure ulcers were healed.

Review of a skin wound note dated 7/17/16, revealed R22 was at high risk for pressure ulcer development.

Review of physician note dated 7/21/16, revealed R22 had been admitted to hospice care due to overall declining condition and dementia.

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:

-6/17/16, revealed R22 had open areas on her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24	F 314		

coccyx and a dressing was applied by the night nurse.

-6/23/16, revealed R22 continued to have an open area on her coccyx which was a pressure ulcer. The note revealed an air alternating mattress was placed on R22's bed for pressure relief and continued to require a turning and repositioning plan.

-7/1/16, revealed R22's pressure ulcer on her coccyx had healed since air mattress was placed.

R22 went 2 hours and 35 minutes without repositioning. On 8/3/16, during continuous observations 7:01 a.m. 9:20 a.m. R22 was not observed to be toileted. On 8/3/16 at 9:25 a.m. nursing assistant (NA)-A stated R22 was up in the wheelchair at 6:45 a.m.

On 8/3/16 at 7:01 a.m. R22 was seated in a tilt in space wheelchair. At 7:22 a.m. R22 remained seated in a tilt in space wheelchair. At 7:31 a.m. rehabilitation aide (RA)-A stood behind R22 and verbalized to the medication nurse she would move R22 back in her wheelchair. RA-A brought R22 to her room. RA-A stated R22 needed to be scooted back into her tilt in space chair. RA-A then asked R22 to lean forward and used the back of R22's blue slacks to pull her buttocks toward the back of the chair. RA-A then adjusted R22's head rest and assisted R22 in her wheelchair back to the common area by the nurses station. RA-A was not observed to offer or assist R22 with repositioning to off load pressure. At 8:05 a.m. R22 remained seated in the tilt in space wheelchair. Nursing assistant (NA)-A approached R22, stated to R22 that it was almost breakfast time. NA-A was not observed to offer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26	F 314		

mattress. NA-A stated R22 needed total assistance with repositioning.

On 8/3/16, at 9:29 a.m. NA-C stated R22 required total assistance with repositioning at least every 2 hours. NA-C stated R22 had skin breakdown on her buttocks within the last month or two and it had healed quickly.

On 8/3/16, at 10:40 a.m. during a follow up interview NA-A stated she had thought R22's hospice NA had assisted R22 to reposition when he was there for cares that morning. NA-A stated when R22's hospice aide would come he was responsible for repositioning. NA-A was not aware he had not done so. NA-A stated she would usually verbally communicate with the hospice aid on what was done for R22 though did not do that at this time. NA-A stated she was busy and was not able to ensure R22 was repositioned.

On 8/3/16, at 10:51 a.m. RN-A stated the usual practice for residents who received hospice care was for the NA's to verbally communicate what cares were provided for R22 prior to the hospice NA leaving. RN-A confirmed the hospice NA note revealed no cares were provided to R22 by the hospice aid. RN-A stated R22 required assistance with repositioning at least every 2 hours. RN-A stated R22 continued to be at high risk for skin breakdown and had a few "superficial" areas on her coccyx in 6/16 which had healed by 7/16. RN-A stated she felt the superficial areas on R22's coccyx were stage one pressure ulcers because they had no depth. She indicated a pressure relieving mattress was put into place as an intervention at that time. RN-A confirmed R22's care plan was current and directed staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 27	F 314		

Continued From page 27

assist R22 with assessed repositioning and toileting needs.

On 8/3/16, at 10:59 a.m. the director of nursing (DON) confirmed R22 was at risk for pressure ulcers. The DON stated she expected staff to follow R22's care plan for the assessed need of repositioning at least every 2 hours.

Review of facility policy and procedure titled, Positioning, revised 3/2009, 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.

R31's quarterly Minimum Data Set (MDS) dated 5/23/16, identified R31 had moderate cognitive impairment, required extensive assistance with all activities of daily living (ADLs) and had upper and lower extremity impairment. The MDS also identified R31 was always incontinent of bowel and bladder and was at risk for developing pressure ulcers and had a pressure relieving device for his chair.

R31's care plan dated 7/7/15, identified R31 had the potential for alteration in skin integrity related to impaired physical mobility, impaired skin integrity, incontinence, poor safety awareness and multiple medical problems. The care plan also identified R31 required extensive assist of 2 staff to turn and reposition in bed and chair every 2 hours and as necessary.

R31's care area assessment (CAA) dated 12/7/15, identified R31 was at risk for developing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 28	F 314		

pressure ulcers as R31 required extensive assistance with ADLs, was always incontinent of bowel and bladder and had weight loss.

Review of R31's progress notes revealed a clinical assessment had been completed on 5/23/16, which included a BRADEN (a scale to evaluate pressure ulcer risk) score. R31's score placed him at risk for pressure ulceration and skin break down. R31 was incontinent of bowel and bladder, had a history of boils on the buttocks, groin and arm pit, was dependent upon staff for incontinence care and R31 was to be turned and repositioned every two hours.

The undated facility form titled Visual/Bedside Kardex Report which served as a nursing assistant care guide, directed staff to turn and reposition R31 every two hours when in bed and chair.

Continuous observation on 8/2/16, from 5:21 p.m. to 8:00 p.m. identified R31 had not been offered or repositioned in his chair. On 8/2/16, at 5:21 p.m. R31 was seated in the dining room at dining room table waiting for his evening meal. Resident's chair was in an upright position. At 5:47 p.m. licensed practical nurse (LPN)-B administered R31's medication. At 6:00 p.m. R31 was fed his meal by nursing assistant (NA)-H. At 6:13 p.m. NA-I broke R31's cookie in half and handed half to him. NA-I told R31 the other half of his cookie on was on his plate and walked away. At 6:29 p.m. NA-E tilted R31's wheelchair back slightly and wheeled him from the dining room to the day area. At 6:37 p.m. R31 remained seated in the day area, asleep in his chair. At 6:48 p.m. R31 continued seated in the day area. At 7:15 p.m. NA-G pulled R31's shirt down over his belly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314		F 314		

Continued From page 29

as his lower belly was exposed. NA-G stated out loud to herself, "I think we'll have to put him to bed soon, I'll have to check with my partner and see what she says." R31's head was hanging forward and to the left, off of the head rest. At 8:00 p.m., after surveyor intervention, R31 was laid down. Observation revealed R31's buttocks were red with creases in buttocks and upper thighs. At that time, RN-B stated the redness was blanchable and the scars observed on the buttocks were from R31's history of boils.

On 8/2/16, at 7:56 p.m. NA-G stated she was was assigned to R31's care for that evening. She stated she didn't know exactly when R31 was last repositioned, but stated it was sometime before supper. NA-G stated R31 was supposed to be repositioned every 2 hours when in his chair or bed. She stated because R31 was asleep in his chair she considered that a refusal. She confirmed she did not offer R31 repositioning. She stated she didn't know if R31 was at risk for pressure ulcers because that was up to the nurses.

On 8/3/16, at 8:26 a.m. registered nurse (RN)-B confirmed R31's care plan and stated R31 should have been repositioned every 2 hours. She confirmed R31's last tissue tolerance test (TTT) (the ability of the skin and its supporting structures to endure the effects of pressure, without adverse effects) was completed on 12/3/15, and identified R31 required every 2 hour repositioning. She confirmed R31's Braden score and that R31 was at risk for developing pressure ulcers. She stated R31 had scar tissue and a history of maceration to his bottom. She confirmed the reason for every 2 hour repositioning was to offload pressure and prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 30	F 314		

skin breakdown. She stated R31 was confused and was unable to make good decisions. She confirmed R31 required extensive to total assistance from staff for repositioning. RN-B confirmed R31 would not be able to offload pressure from his bottom while in his chair without staff assistance. She confirmed she was charge nurse last night and expected staff to offer and reposition R31 every 2 hours.

On 8/3/16, at 10:54 a.m. trained medication assistant (TMA)-B stated she felt R31 was at risk for developing pressure ulcers and stated he had a history of skin issues on his bottom. TMA-B stated current interventions to keep R31's skin intact were to reposition R31 every 2 hours and use barrier cream on his bottom. She stated R31 should be repositioned every 2 hours. She stated R31 was totally dependent on staff for bed mobility and repositioning. She stated R31's care plan directed staff to turn and reposition R31 every 2 hours.

On 8/3/16, at 11:48 a.m. NA-D stated R31 was confused and was totally dependent on staff for cares. She stated R31's care plan directed them to reposition him every 2 hours to prevent open areas. She stated she didn't think R31 was at risk for developing pressure ulcers.

On 8/3/16, at 1:10 p.m. the director of nurses (DON) stated R31 was at risk for developing pressure ulcers and required repositioning every 2 hours. The DON confirmed R31 required extensive assistance with repositioning and was totally dependent on staff for repositioning. She confirmed R31 had alterations in thought processes and impaired communication skills. She stated she would expect staff to follow the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 31 plan of care and reposition R31 every 2 hours to prevent the development of pressure ulcers. Review of facility policy and procedure titled, 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.	F 314		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical	F 334		9/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334		F 334		

Continued From page 32
contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Pneumococcal Conjugate Vaccine-13 (PCV13) vaccines were offered to 3 of 5 residents (R28, R23, R27) as recommended by the Centers for Disease Control and Prevention (CDC) and failed to develop guidelines for PCV13. Findings include: The CDC guidelines updated 7/16/14, identified PCV13, also called Prevnar, protected against the 13 most common types of pneumonia. The Advisory Committee on Immunization Practices (ACIP) recommends that all adults 65 years of age or older receive a dose of PCV13. R28's Immunization Audit Report dated 8/4/16, indicated the 77 year old had received Pneumovax dose 1 on 1/4/12. However, the medical record lacked evidence R20 was offered the PCV-13 vaccination as recommended by the CDC. R23's Immunization Audit Report dated 8/4/16, indicated the 92 year old had received Pneumovax dose 1 on 9/13/14. However, the medical record lacked evidence R23 was offered the PCV-13 vaccination as recommended by the CDC. R27's Immunization Audit Report dated 8/4/16, indicated the 85 year old had received Pneumovax dose 1 on 1/2/1998. However, the medical record lacked evidence R27 was offered the PCV-13 vaccination as recommended by the CDC.	F 334	F334 It is the policy of Halstad Living Center to provide immunizations as recommended by the ACIP, per their schedule unless the immunization is medically contraindicated or the resident has already been immunized during a previous time period. Corrective action for the residents affected by the alleged deficient practice: Res #28, 23, & 27 had received Pneumovax dose #1 (PPSV23), without being offered a second dose of Pneumovax (PCV13). Consent forms were ordered on 8/23/16 and will be sent out to all residents and or family members who are affected by the alleged deficient practice. Consent forms will be sent out on or before Sept 8th, 2016. Corrective action taken for those residents having been affected: Residents that meet the criteria will be offered PCV13 & PPSV23 upon admission to the facility. All current residents immunization records have been reviewed and physicians orders received to administer per ACIP schedule. DON/Designee will visually audit all new admissions until 100% compliance is achieved. This will be completed on or before Sept 8th, 2016 by DON/Designee. The policy and procedure has been updated to include PCV13 with the current recommended ACIP schedule. Licensed nursing staff to be in serviced by DON/Designee on Policy and procedure for properly administering pneumovax PCV13 on or before Sept 8th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING ______ 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**

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F 334	Continued From page 34 On 8/4/16, at 9:34 a.m. the director of nursing (DON) who was currently responsible for the facility's infection control program, confirmed the facility policy did not reflect the CDC guidelines for PCV-13. The DON confirmed they were aware of a new CDC recommendation related to PCV-13, but the DON did not know the specifics. The DON indicated the recommendation had been discussed; however, it had not become a standard of practice to offer/administer the vaccination to the residents. Currently, the vaccine would only be administered if the physician specifically ordered it. The DON confirmed the CDC guidelines for PCV-13 had not been followed, as residents had not been routinely offered the PCV-13. No further documentation was submitted for review. The facility's Pneumococcal Vaccine Policy revised 4/09, indicated all resident would be offered the Pneumovax (Pneumococcal vaccine) to aid in preventing Pneumococcal infections. The policy, however, did not incorporate the new CDC guidelines to ensure residents were offered timely immunizations of PCV-13.	F 334	Results of audits will be reviewed by QA committee quarterly until 100% compliance attained/maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/08/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST** **HALSTAD, MN 56548**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshal Division. At the time of this survey Halstad Living Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST** **HALSTAD, MN 56548**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us 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. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Halstad Living Center was built in 1977 as a 1-story building without a basement and was determined to be Type II (000) construction. In 1990 a 1-story addition to the dining room was constructed to the east of the original building and was determined to be Type II (111) construction. In 1998 a dining addition was constructed to the west of 200 wing and an addition to the south to connect to the apartment building. These additions are 1 story without a basement and were determined to be of a Type II (111) construction. The building is divided into 5 smoke zones with 1/2 hour fire rated barriers. The entire building is sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas, installed in accordance with NFPA 72 "The National Fire	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building. The facility has a capacity of 44 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the corridor and adjacent areas making them untenable, which could negatively affect the exiting capabilities for 29 of the 40 residents and	K 029	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 report findings to the Safety Committee quarterly.	8/9/16

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	245569	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/08/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALSTAD LIVING CENTER	**133 FOURTH AVENUE EAST** **HALSTAD, MN 56548**

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K 029	Continued From page 3 an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 12:30 pm on 08/08/2016 observations and staff interview revealed the following two doors did not close and latch automatically. 1. Storage room 300 2. Soiled utility room 202 This deficient condition was verified by the Facility Admiistrator and the Maintenance Engineer.	K 029		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improperly trained staff would affect the safe evacuation of all 40 residents and undetermined amount of staff and visitors	K 050	One staff member per shift has been 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 and Safety Committees quarterly and reported to the Administrator monthly to ensure compliance.	8/9/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 050	Continued From page 4 Findings include: On the facility tour between 9:30 am to 12:30 pm on 08/08/2016 record review and staff interview revealed in the last four quarters, a fire drill was missed on the 3rd shift in the 3rd quarter of 2015 and one was missed on the 2nd shift in the 4th quarter of 2015. This deficient condition was verified by the Facility Administrator and the Maintenance Engineer.	K 050		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and staff interview, the facility failed to monitor the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition. This deficient practice could affect the safety of all 40 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 12:30 pm on 08/08/2016 record review and staff interview revealed the generator cool down cycle was not being logged. This deficient condition was verified by the Facility Administrator and the Maintenance Engineer.	K 144	The generator cool down cycle is now being logged on the current generator log and will be done with every report. Findings will be reviewed with the QA committee quarterly to ensure compliance.	8/9/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245569	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/08/2016**

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K 144	Continued From page 5	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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: Based on observation and interview with the staff, the facility was using an unapproved electrical device that is not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of 4 of the 40 residents, and an undetermined amount of staff and visitors. 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.	K 147	The non listed electrical adapter in the clean utility room 109 was removed. All rooms were inspected for non listed electrical devices. Quarterly walk-throughs will be conducted by Maintenance staff to ensure no further use of non listed electrical devices. This report will be reviewed by the QA and Safety Committees quarterly.	8/9/16

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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.

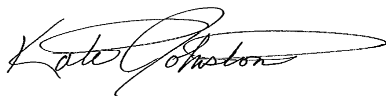
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/1-4/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were free from physical restraint for 1 of 3 residents (R22) reviewed for restraints. 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) and used a wheelchair for locomotion. The MDS did not identify R22 had a physical restraint during the 7 day assessment period. Review of R22's current care plan dated 7/17/16, revealed R22 had severe cognitive impairment and required total assistance from facility staff for ADL's. R22's care plan revealed R22 used a tilt in space chair and required assistance with locomotion to destinations. R22's care plan	2 510	Corrected.	8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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

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2 510	Continued From page 3	2 510		

lacked documentation to lock her wheelchair brakes.

Review of R22's medical record revealed no restraint assessments.

Review of R22's progress notes form 2/4/16, to 7/29/16, revealed no documentation on use of a wheelchair restraint for R22.

On 8/3/16, R22 was continuously observed from 7:01 a.m. to 8:14 a.m. At 7:01 a.m. R22 was seated in a tilt in space chair. R22 was observed to have her eyes open and was looking around. R22's right wheelchair brake was locked. At 7:22 a.m. R22 remained seated in the tilt in space wheelchair with her eyes closed and her wheelchair brake locked. R22's right foot was on the floor and her left foot was on the wheelchair foot rest. At 7:28 a.m. R22 remained seated in the tilt in space chair near the nurses station with her eyes open. R22 placed her right foot on the footrest of the wheelchair, reached down with her right arm and grabbed hold of the right wheel of the wheelchair. R22 attempted to propel her wheelchair with her right arm and was unable to move forward as the wheelchair brake was locked. R22 placed both feet on the floor and began to repeatedly tap both feet on the floor. The director of nursing (DON) was observed to walk past R22 seated in the wheelchair, but did not approach R22. Nursing assistant (NA)-A and registered nurse (RN)-A were observed to walk near R22 at the nurses station, but did not approach her or disengage the wheelchair brake. At 7:30 a.m. R22 remained seated in the tilt in space chair, with the right brake engaged. R22 reached down with her right hand to the wheelchair wheel and attempted to propel the wheelchair forward. R22 was unable to move her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 510	Continued From page 4	2 510		

wheelchair. Rehab aid (RA)-A was observed near R22 in the wheelchair at that time, and did not provide assistance. At 7:31 a.m. RA-A stood behind R22, verbalized to the medication nurse she would move R22 back in her wheelchair. RA-A reached down and released the brake on R22's right wheel and assisted R22 in the wheelchair to her room. Upon entering R22's room, RA-A stated R22 needed to be scooted back into her tilt in space chair. RA-A then asked R22 to lean forward and used the back of R22's blue slacks to pull her buttocks towards the back of the chair. RA-A then adjusted R22's head rest and assisted R22 in her wheelchair back to the common area by the nurses station. RA-A did not lock R22's wheelchair brake. R22 remained in the tilt in space wheelchair propelling herself around the common area.

On 8/3/16, at 7:36 a.m. RA-A stated it was usual practice to lock a brake on R22's chair depending on how she had been doing. RA-A stated R22 was able to propel herself in the tilt in space chair but at times could not and that's when R22's wheelchair brakes were locked for safety. At 8:05 a.m. R22 remained seated in the tilt in space wheelchair and propelled her wheelchair 2 doors down the 300 wing hallway. NA-A approached R22 and stated it was almost breakfast time. NA-A turned R22's wheelchair around and brought R22 back to the common area by the nurses station where she stopped next to another residents wheelchair. NA-A then reached down and engaged R22's left wheelchair brake and immediately walked away from the area. At 8:10 a.m. RN-A walked over to R22 in the wheelchair, stood at R22's left side and spoke with her about the upcoming breakfast meal. RN-A proceeded to walk away from R22, had not disengaged R22's left wheelchair brake. At 8:13 a.m. licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 510	Continued From page 5	2 510		

Continued From page 5

practical nurse (LPN)-A approached R22 in her wheelchair and administered medications to R22. LPN-A attempted to move R22's wheelchair forward, and was unable to move the wheelchair with the brake engaged. LPN-A disengaged the brake and moved R22 toward the dining room. NA-A took R22 to the dining room, and brought her to the table. NA-A reached down and engaged R22's right brake. R22 remained seated in her tilt in space wheelchair at the table from 8:14 a.m. to 8:54 a.m. to eat breakfast. R22's wheelchair brake remained engaged/locked during the entire breakfast meal.

On 8/3/16, at 8:16 a.m. LPN-A stated R22 could propel herself in the tilt in space chair and could not recall unlocking R22's wheelchair brake. LPN-A stated R22's wheelchair brakes should not be locked as she could "meander" around. LPN-A stated R22 needed assistance to reach destinations, but could wheel herself a fair distance. At 8:54 a.m. NA-A approached R22, disengaged her right brake and assisted R22 out of the dining room into the common area by the nurses station. NA-A did not engage/ lock R22's wheelchair brake. Activity aid (AA)-A approached R22 and offered an opportunity to fold towels. After R22 agreed, AA-A assisted R22 out of the common area into the activity room.

On 8/3/16, at 8:22 a.m. RN-A confirmed R22 was able to propel her wheelchair independently at times. RN-A stated engaging the brakes on R22's wheelchair would be considered a restraint. RN-A also stated R22 did not have a physician's order for the use of a restraint. RN-A confirmed R22's current 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 510	Continued From page 6	2 510		

Continued From page 6

(DON) confirmed R22 could propel herself in her wheelchair and indicated locking either wheelchair brake would be considered a restraint for R22. The DON stated she would expect staff to 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 was locking resident wheelchair brakes. She indicated she had questioned staff about why they were locking brakes and the DON believed this practice had become habit with some staff.

On 8/3/16, at 9:25 a.m. NA-A stated she would routinely lock R22's brake so R22 did not roll away. NA-A stated R22 had not rolled away before, but felt as a safety measure she would lock R22's brake. NA-A stated R22 could propel herself in her wheelchair but would not be able to go to a specific destination due to cognitive impairment. NA-A stated locking R22's wheelchair brake would prevent her from independently propelling herself. NA-A stated she locked the brake out of habit.

A facility policy and procedure titled, Physical Restraint, revised 5/09, identified the definition of a physical restraint was any manual method or physical or mechanical device, material or equipment which would restrict an individuals freedom of movement or access to ones body. The policy directed staff physical restraints were only to be used when ordered or in a medical emergency.

SUGGESTED METHOD FOR CORRECTION:
The director of nursing (DON) or designee could develop systems to ensure staff do not implement restraints without an assessed need. The DON or designee could educate all appropriate staff. The DON or designee could conduct audits to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 510	Continued From page 7 ongoing compliance and report the audit results to the QA committee. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 510		
2 520	MN Rule 4658.0300 Subp. 3 B Use of Restraints Subp. 3. Emergency use of restraint. B. If a restraint is needed, a physician's order must be obtained which specifies the duration and circumstances under which the restraint is to be used. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were free from physical restraint for 1 of 3 residents (R22) reviewed for restraints. 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) and used a wheelchair for locomotion. The MDS did not identify R22 had a physical restraint during the 7 day assessment period. Review of R22's current care plan dated 7/17/16, revealed R22 had severe cognitive impairment and required total assistance from facility staff for ADL's. R22's care plan revealed R22 used a tilt in	2 520	Corrected.	8/26/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 520	Continued From page 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.

Review of R22's progress notes form 2/4/16, to 7/29/16, revealed no documentation on use of a wheelchair restraint for R22.

On 8/3/16, R22 was continuously observed from 7:01 a.m. to 8:14 a.m. At 7:01 a.m. R22 was seated in a tilt in space chair. R22 was observed to have her eyes open and was looking around. R22's right wheelchair brake was locked. At 7:22 a.m. R22 remained seated in the tilt in space wheelchair with her eyes closed and her wheelchair brake locked. R22's right foot was on the floor and her left foot was on the wheelchair foot rest. At 7:28 a.m. R22 remained seated in the tilt in space chair near the nurses station with her eyes open. R22 placed her right foot on the footrest of the wheelchair, reached down with her right arm and grabbed hold of the right wheel of the wheelchair. R22 attempted to propel her wheelchair with her right arm and was unable to move forward as the wheelchair brake was locked. R22 placed both feet on the floor and began to repeatedly tap both feet on the floor. The director of nursing (DON) was observed to walk past R22 seated in the wheelchair, but did not approach R22. Nursing assistant (NA)-A and registered nurse (RN)-A were observed to walk near R22 at the nurses station, but did not approach her or disengage the wheelchair brake. At 7:30 a.m. R22 remained seated in the tilt in space chair, with the right brake engaged. R22 reached down with her right hand to the

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2 520	Continued From page 9	2 520		

wheelchair wheel and attempted to propel the wheelchair forward. R22 was unable to move her wheelchair. Rehab aid (RA)-A was observed near R22 in the wheelchair at that time, and did not provide assistance. At 7:31 a.m. RA-A stood behind R22, verbalized to the medication nurse she would move R22 back in her wheelchair. RA-A reached down and released the brake on R22's right wheel and assisted R22 in the wheelchair to her room. Upon entering R22's room, RA-A stated R22 needed to be scooted back into her tilt in space chair. RA-A then asked R22 to lean forward and used the back of R22's blue slacks to pull her buttocks towards the back of the chair. RA-A then adjusted R22's head rest and assisted R22 in her wheelchair back to the common area by the nurses station. RA-A did not lock R22's wheelchair brake. R22 remained in the tilt in space wheelchair propelling herself around the common area.

On 8/3/16, at 7:36 a.m. RA-A stated it was usual practice to lock a brake on R22's chair depending on how she had been doing. RA-A stated R22 was able to propel herself in the tilt in space chair but at times could not and that's when R22's wheelchair brakes were locked for safety. At 8:05 a.m. R22 remained seated in the tilt in space wheelchair and propelled her wheelchair 2 doors down the 300 wing hallway. NA-A approached R22 and stated it was almost breakfast time. NA-A turned R22's wheelchair around and brought R22 back to the common area by the nurses station where she stopped next to another residents wheelchair. NA-A then reached down and engaged R22's left wheelchair brake and immediately walked away from the area. At 8:10 a.m. RN-A walked over to R22 in the wheelchair, stood at R22's left side and spoke with her about the upcoming breakfast meal. RN-A proceeded to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 520	Continued From page 10	2 520		

walk away from R22, had not disengaged R22's left wheelchair brake. At 8:13 a.m. licensed practical nurse (LPN)-A approached R22 in her wheelchair and administered medications to R22. LPN-A attempted to move R22's wheelchair forward, and was unable to move the wheelchair with the brake engaged. LPN-A disengaged the brake and moved R22 toward the dining room. NA-A took R22 to the dining room, and brought her to the table. NA-A reached down and engaged R22's right brake. R22 remained seated in her tilt in space wheelchair at the table from 8:14 a.m. to 8:54 a.m. to eat breakfast. R22's wheelchair brake remained engaged/locked during the entire breakfast meal.

On 8/3/16, at 8:16 a.m. LPN-A stated R22 could propel herself in the tilt in space chair and could not recall unlocking R22's wheelchair brake. LPN-A stated R22's wheelchair brakes should not be locked as she could "meander" around. LPN-A stated R22 needed assistance to reach destinations, but could wheel herself a fair distance. At 8:54 a.m. NA-A approached R22, disengaged her right brake and assisted R22 out of the dining room into the common area by the nurses station. NA-A did not engage/ lock R22's wheelchair brake. Activity aid (AA)-A approached R22 and offered an opportunity to fold towels. After R22 agreed, AA-A assisted R22 out of the common area into the activity room.

On 8/3/16, at 8:22 a.m. RN-A confirmed R22 was able to propel her wheelchair independently at times. RN-A stated engaging the brakes on R22's wheelchair would be considered a restraint. RN-A also stated R22 did not have a physician's order for the use of a restraint. RN-A confirmed R22's current care plan did not direct staff to lock R22's wheelchair brakes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ____ B. WING ____	08/04/2016

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2 520	Continued From page 11 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 for R22. The DON stated she would expect staff to 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 was locking resident wheelchair brakes. She indicated she had questioned staff about why they were locking brakes and the DON believed this practice had become habit with some staff. On 8/3/16, at 9:25 a.m. NA-A stated she would routinely lock R22's brake so R22 did not roll away. NA-A stated R22 had not rolled away before, but felt as a safety measure she would lock R22's brake. NA-A stated R22 could propel herself in her wheelchair but would not be able to go to a specific destination due to cognitive impairment. NA-A stated locking R22's wheelchair brake would prevent her from independently propelling herself. NA-A stated she locked the brake out of habit. A facility policy and procedure titled, Physical Restraint, revised 5/09, identified the definition of a physical restraint was any manual method or physical or mechanical device, material or equipment which would restrict an individuals freedom of movement or access to ones body. The policy directed staff physical restraints were only to be used when ordered or in a medical emergency. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure staff obtain a physician's order when a restraint is assessed to	2 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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**

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2 520	Continued From page 12 be necessary. The DON or designee could educate all appropriate staff. The DON or designee could conduct audits to ensure ongoing compliance and report the audit results to the QA committee. TIME PERIOD FOR CORRECTION: Twenty (21) days	2 520		
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were free from physical restraint for 1 of 3 residents (R22) reviewed for restraints. Findings include: R22's quarterly Minimum Data Set (MDS) dated	2 530	Corrected.	8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 530	Continued From page 13	2 530		

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) and used a wheelchair for locomotion. The MDS did not identify R22 had a physical restraint during the 7 day assessment period.

Review of R22's current care plan dated 7/17/16, revealed R22 had severe cognitive impairment and required total assistance from facility staff for ADL's. R22's care plan revealed R22 used a tilt in 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.

Review of R22's progress notes form 2/4/16, to 7/29/16, revealed no documentation on use of a wheelchair restraint for R22.

On 8/3/16, R22 was continuously observed from 7:01 a.m. to 8:14 a.m. At 7:01 a.m. R22 was seated in a tilt in space chair. R22 was observed to have her eyes open and was looking around. R22's right wheelchair brake was locked. At 7:22 a.m. R22 remained seated in the tilt in space wheelchair with her eyes closed and her wheelchair brake locked. R22's right foot was on the floor and her left foot was on the wheelchair foot rest. At 7:28 a.m. R22 remained seated in the tilt in space chair near the nurses station with her eyes open. R22 placed her right foot on the footrest of the wheelchair, reached down with her right arm and grabbed hold of the right wheel of the wheelchair. R22 attempted to propel her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HALSTAD LIVING CENTER	133 FOURTH AVENUE EAST HALSTAD, MN 56548

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2 530	Continued From page 14 wheelchair with her right arm and was unable to move forward as the wheelchair brake was locked. R22 placed both feet on the floor and began to repeatedly tap both feet on the floor. The director of nursing (DON) was observed to walk past R22 seated in the wheelchair, but did not approach R22. Nursing assistant (NA)-A and registered nurse (RN)-A were observed to walk near R22 at the nurses station, but did not approach her or disengage the wheelchair brake. At 7:30 a.m. R22 remained seated in the tilt in space chair, with the right brake engaged. R22 reached down with her right hand to the wheelchair wheel and attempted to propel the wheelchair forward. R22 was unable to move her wheelchair. Rehab aid (RA)-A was observed near R22 in the wheelchair at that time, and did not provide assistance. At 7:31 a.m. RA-A stood behind R22, verbalized to the medication nurse she would move R22 back in her wheelchair. RA-A reached down and released the brake on R22's right wheel and assisted R22 in the wheelchair to her room. Upon entering R22's room, RA-A stated R22 needed to be scooted back into her tilt in space chair. RA-A then asked R22 to lean forward and used the back of R22's blue slacks to pull her buttocks towards the back of the chair. RA-A then adjusted R22's head rest and assisted R22 in her wheelchair back to the common area by the nurses station. RA-A did not lock R22's wheelchair brake. R22 remained in the tilt in space wheelchair propelling herself around the common area. On 8/3/16, at 7:36 a.m. RA-A stated it was usual practice to lock a brake on R22's chair depending on how she had been doing. RA-A stated R22 was able to propel herself in the tilt in space chair but at times could not and that's when R22's wheelchair brakes were locked for safety. At 8:05	2 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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

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2 530	Continued From page 15 a.m. R22 remained seated in the tilt in space wheelchair and propelled her wheelchair 2 doors down the 300 wing hallway. NA-A approached R22 and stated it was almost breakfast time. NA-A turned R22's wheelchair around and brought R22 back to the common area by the nurses station where she stopped next to another residents wheelchair. NA-A then reached down and engaged R22's left wheelchair brake and immediately walked away from the area. At 8:10 a.m. RN-A walked over to R22 in the wheelchair, stood at R22's left side and spoke with her about the upcoming breakfast meal. RN-A proceeded to walk away from R22, had not disengaged R22's left wheelchair brake. At 8:13 a.m. licensed practical nurse (LPN)-A approached R22 in her wheelchair and administered medications to R22. LPN-A attempted to move R22's wheelchair forward, and was unable to move the wheelchair with the brake engaged. LPN-A disengaged the brake and moved R22 toward the dining room. NA-A took R22 to the dining room, and brought her to the table. NA-A reached down and engaged R22's right brake. R22 remained seated in her tilt in space wheelchair at the table from 8:14 a.m. to 8:54 a.m. to eat breakfast. R22's wheelchair brake remained engaged/locked during the entire breakfast meal. On 8/3/16, at 8:16 a.m. LPN-A stated R22 could propel herself in the tilt in space chair and could not recall unlocking R22's wheelchair brake. LPN-A stated R22's wheelchair brakes should not be locked as she could "meander" around. LPN-A stated R22 needed assistance to reach destinations, but could wheel herself a fair distance. At 8:54 a.m. NA-A approached R22, disengaged her right brake and assisted R22 out of the dining room into the common area by the nurses station. NA-A did not engage/ lock R22's	2 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

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2 530	Continued From page 16	2 530		

wheelchair brake. Activity aid (AA)-A approached R22 and offered an opportunity to fold towels. After R22 agreed, AA-A assisted R22 out of the common area into the activity room.

On 8/3/16, at 8:22 a.m. RN-A confirmed R22 was able to propel her wheelchair independently at times. RN-A stated engaging the brakes on R22's wheelchair would be considered a restraint. RN-A also stated R22 did not have a physician's order for the use of a restraint. RN-A confirmed R22's current 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 for R22. The DON stated she would expect staff to 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 was locking resident wheelchair brakes. She indicated she had questioned staff about why they were locking brakes and the DON believed this practice had become habit with some staff.

On 8/3/16, at 9:25 a.m. NA-A stated she would routinely lock R22's brake so R22 did not roll away. NA-A stated R22 had not rolled away before, but felt as a safety measure she would lock R22's brake. NA-A stated R22 could propel herself in her wheelchair but would not be able to go to a specific destination due to cognitive impairment. NA-A stated locking R22's wheelchair brake would prevent her from independently propelling herself. NA-A stated she locked the brake out of habit.

A facility policy and procedure titled, Physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 530	Continued From page 17 Restraint, revised 5/09, identified the definition of a physical restraint was any manual method or physical or mechanical device, material or equipment which would restrict an individuals freedom of movement or access to ones body. The policy directed staff physical restraints were only to be used when ordered or in a medical emergency. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure staff complete a comprehensive assessment to determine if a restraint is necessary. The DON or designee could educate all appropriate staff. The DON or designee could conduct audits to ensure ongoing compliance and report the audit results to the QA committee. TIME PERIOD FOR CORRECTION: Twenty (21) days	2 530		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 560	Corrected.	8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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**

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2 560	Continued From page 18	2 560		

Continued From page 18

review the facility failed to revise the plan of care for 1 of 1 residents (R31) reviewed with a catheter.

Findings include:

R31's quarterly Minimum Data Set (MDS) dated 5/23/16, identified R31 had moderate cognitive impairment, required extensive assistance with all activities of daily living (ADLs) and had upper and lower extremetity impairment. The MDS also identified R31 was always incontinent of bowel and bladder.

R31's care plan dated 7/7/16, identified R31 had an indwelling catheter placed 7/5/16, for an inability to void for extended periods of time. Staff was to monitor for odorous urine, change the Foley catheter monthly and the Foley bag every 2 weeks. Although facility staff was aware of odor and identified multiple interventions they could attempt, the care plan failed to identify additional catheter cares for minimizing the urine odor for R31.

On 8/1/16, at 5:00 p.m. R31 was in his wheelchair in his room in front of the TV. R31 had a catheter bag contained in a cloth bag on the side of his wheelchair. R31's bedroom had a strong, foul, concentrated urine odor.

On 8/3/16, at 7:15 a.m. R31 was observed in bed asleep with the catheter collection bag inside a cloth bag which sat on the floor next to his bed. A small silver pitcher to measure urine output and and empty urinal were on the back of R31's toilet. R31's bedroom and bathroom continued to have a strong, foul, concentrated urine odor.

On 8/3/16, at 8:26 a.m. registered nurse (RN-B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

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2 560	Continued From page 19	2 560		

stated she was aware of R31's urine odor and stated the urine odor started soon after R31's catheter was placed. She stated she felt there was sediment in the tube that could be causing the odor and the catheter should be gone through to check what was causing the urine odor. She stated R31's 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.

On 8/3/16, at 10:54 a.m. trained medication assistant (TMA)-B stated R31's urine in the bag is dark and the odor started with the initiation of the catheter. She stated when she noticed the odor the nurses would have to change it. TMA-B stated she didn't know if she told the nurse about R31's odor before today. She stated all catheters had an odor. She stated she washed R31's perineal area with soap and water, emptied R31's foley bag and confirmed she didn't rinse out the bag but closed it back up.

On 8/3/16, at 11:28 a.m. during a follow-up interview RN-B stated NA's open the catheter bag, emptied the bag and closed the bag and washed surrounding skin with soap and water. She confirmed NA's didn't rinse out the bag after it was emptied. She stated the LPN was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

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2 560	Continued From page 20 responsible for irrigating with vinegar during the evening or night shift. RN-B stated she didn't know where the odor was coming from and stated the odor hung in the bag and in the tubing. She stated when she noticed the odor the other day it was really bad and she should have changed his catheter at that time. She stated she talked to the night nurse the other night and had her to irrigate the tubing with plain water and stated she felt it helped. On 8/3/16, at 11:48 a.m. NA-D stated she noticed R31's urine odor today and she told the nurse. She stated she washed R31's perineal area with soap and water and emptied the catheter bag. She confirmed she didn't rinse the bag after she emptied it. On 8/3/16, at 12:25 p.m. RN-B confirmed strong urine odor in R31's bedroom and bathroom. RN confirmed the urine odor in the bathroom was from the pitcher and urinal on the back of R31's toilet which were used to measure urine from R31's catheter bag. RN lifted R31's catheter bag from the cloth bag on the floor that contained 120 cc of light brown urine and confirmed the strong urine odor was from R31's catheter bag. She stated she felt R31's urine looked pretty good as there were no "chunks in it". She stated the NA's don't rinse the bag after emptying which would have caused more odor. She stated they could have rinsed the bag after emptying, used a leg bag, and rinsed the bag every day with vinegar, used 2 different bags alternating, or try odor control drops or efferdent tablets in the bag to control R31's urine odor. On 8/3/16, at 1:10 p.m. the director of nursing (DON) stated she would expect staff to follow the plan of care and R31 to be free of urine odor. She	2 560		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 560	Continued From page 21 stated she was not aware that R31 had urine odor until today. Review of facility policy and procedure titled, Care Planning, revised 4/04, revealed it was a policy of the facility to develop individualized care plans for residents which would address assessed needs and interventions in place based upon assessment. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure timely revisions to the individualized resident plans of care. The DON or designee could educate all appropriate staff. The DON or designee could develop an auditing system to ensure ongoing compliance and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: 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.	2 565	Corrected.	8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

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2 565	Continued From page 22	2 565		

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 devices for chair and mattress surfaces.

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 pressure ulcer interventions in place included a pressure air relieving mattress to R22's bed and a pressure relieving pad to recliner. R22's care plan directed facility staff to assist R22 to turn and reposition at least every 2 hours and as needed with 2 staff assistance. Review of R22's current care plan revised 7/24/16, directed facilty staff to assist R22 with toileting at least every 2 hours and to check R22's incontinent brief every 2 hours for total bowel and bladder incontinence.

R22 remained seated in the same position from 6:45 a.m. to 9:20 a.m., a total of 2 hours and 35 minutes. On 8/3/16, during continuous observations 7:01 a.m. 9:20 a.m. R22 was not observed to be repositioned or checked/changed. R22 was observed to remain in her tilt in space wheelchair from 7:01 a.m. through 9:20 a.m. without offloading from her buttocks or offer/provision of toileting services.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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**

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2 565	Continued From page 23	2 565		

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.

On 8/3/16, at 9:29 a.m. NA-C stated R22 required total assistance with repositioning and checking and changing at least every 2 hours.

On 8/3/16, at 10:40 a.m. during a follow up interview NA-A stated she had though R22's hospice aide had assisted R22 to reposition when he was there for cares that morning. NA-A stated when R22's hospice aide would come he was responsible for repositioning and checking and changing R22 and was not aware he had not done so.

On 8/3/16, at 10:51 a.m. RN-A confirmed the hospice NA note revealed no cares were provided to R22 by the hospice aid. RN-A stated R22 required assistance with repositioning, checking and changing at least every 2 hours. RN-A confirmed R22's care plan was current and directed staff to assist R22 with assessed repositioning and toileting needs.

On 8/3/16, at 10:59 a.m. the director of nursing (DON) stated she expected staff to follow R22's care plan for the assessed needs of repositioning and checking and changing at least every 2 hours.

Review of facility policy and procedure titled, Care Planning, revised 4/04, revealed it was a policy of the facilty to develop individualized care plans for residents which would address assessed needs and interventions in place based upon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 565	Continued From page 24 assessment. R31's quarterly Minimum Data Set (MDS) dated 5/23/16, identified R31 was always incontinent of bowel and bladder and was at risk for developing pressure ulcers and had a pressure relieving device for his chair. R31's care plan dated 7/7/15, identified R31 had the potential for alteration in skin integrity related to impaired physical mobility, impaired skin integrity, incontinence, poor safety awareness and multiple medical problems. The care plan also identified R31 required extensive assist of 2 staff to turn and reposition in bed and chair every 2 hours and as necessary. R31's care area assessment (CAA) dated 12/7/15, identified R31 was at risk for developing pressure ulcers as R31 required extensive assistance with ADLs, was always incontinent of bowel and bladder and had weight loss. The undated facility form titled Visual/Bedside Kardex Report which served as a nursing assistant care guide, directed staff to turn and reposition R31 every two hours when in bed and chair. Continuous observation on 8/2/16, from 5:21 p.m. to 8:00 p.m. identified R31 had not been offered or repositioned in his chair. On 8/2/16, at 5:21 p.m. R31 was seated in the dining room at dining room table waiting for his evening meal. Resident's chair was in an upright position. At 5:47 p.m. licensed practical nurse (LPN)-B administered R31's medication. At 6:00 p.m. R31 was fed his meal by nursing assistant (NA)-H. At 6:29 p.m. NA-E tilted R31's wheelchair back slightly and wheeled him from the dining room to	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 25	2 565		

the day area. At 7:15 p.m. NA-G pulled R31's shirt down over his belly as his lower belly was exposed. NA-G stated out loud to herself, "I think we'll have to put him to bed soon, I'll have to check with my partner and see what she says." R31's head was hanging forward and to the left, off of the head rest. At 8:00 p.m., after surveyor intervention, R31 was laid down.

On 8/2/16, at 7:56 p.m. NA-G stated she was was assigned to R31's care for that evening. She stated she didn't know exactly when R31 was last repositioned, but stated it was sometime before supper. NA-G stated R31 was supposed to be repositioned every 2 hours when in his chair or bed. She confirmed she did not offer R31 repositioning.

On 8/3/16, at 8:26 a.m. registered nurse (RN)-B confirmed R31's care plan and stated R31 should have been repositioned every 2 hours. She confirmed the reason for every 2 hour repositioning was to offload pressure and prevent skin breakdown. She confirmed R31 required extensive to total assistance from staff for repositioning. RN-B confirmed R31 would not be able to offload pressure from his bottom while in his chair without staff assistance.

On 8/3/16, at 10:54 a.m. trained medication assistant (TMA)-B stated current interventions to keep R31's skin intact were to reposition R31 every 2 hours and use barrier cream on his bottom. She stated R31 should be repositioned every 2 hours. She stated R31 was totally dependent on staff for bed mobility and repositioning. She stated R31's care plan directed staff to turn and reposition R31 every 2 hours.

On 8/3/16, at 11:48 a.m. NA-D stated R31's care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ___ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 26 plan directed them to reposition him every 2 hours to prevent open areas. On 8/3/16, at 1:10 p.m. the director of nurses (DON) stated R31 was at risk for developing pressure ulcers and required repositioning every 2 hours. The DON confirmed R31 required extensive assistance with repositioning and was totally dependent on staff for repositioning. She stated she would expect staff to follow the plan of care and reposition R31 every 2 hours to prevent the development of pressure ulcers. Review of facility policy and procedure titled, 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. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure implementation of the individualized resident plans of care. The DON or designee could educate all appropriate staff. The DON or designee could develop an auditing system to ensure ongoing compliance and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the	2 900		8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 27	2 900		

Continued From page 27

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 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 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ B. WING ______	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 900	Continued From page 28	2 900		

incontinence. R22's care plan identified current pressure ulcer interventions in place included a pressure air relieving mattress to R22's bed and a pressure relieving pad to recliner. R22's care plan directed facility staff to assist R22 to turn and reposition at least every 2 hours and as needed with 2 staff assistance.

Review of a tissue tolerance (TT), the ability of the skin and its supporting structures to endure the effects of pressure, without adverse effects, dated 7/26/16, identified R22's skin was intact and was able to tolerate every 2 hour repositioning.

Review of a skin wound note dated 4/24/16, revealed R22 continued to require assistance from staff for daily cares and needs. The note revealed R22 was at high risk for skin breakdown, was frequently incontinent of bowel and bladder and required staff assistance for needs.

Review of a skin wound note dated 6/21/16, revealed R22 had 3 stage I pressure ulcers (non-blanchable erythema of intact skin) on her coccyx which measured 0.75 centimeters (cm) x 0.75 cm. The note revealed a pressure relieving mattress was implemented to aid in healing.

Review of a skin wound note dated 7/1/16, revealed R22's pressure ulcers were healed.

Review of a skin wound note dated 7/17/16, revealed R22 was at high risk for pressure ulcer development.

Review of physician note dated 7/21/16, revealed R22 had been admitted to hospice care due to overall declining condition and dementia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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**

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2 900	Continued From page 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:

-6/17/16, revealed R22 had open areas on her coccyx and a dressing was applied by the night nurse.

-6/23/16, revealed R22 continued to have an open area on her coccyx which was a pressure ulcer. The note revealed an air alternating mattress was placed on R22's bed for pressure relief and continued to require a turning and repositioning plan.

-7/1/16, revealed R22's pressure ulcer on her coccyx had healed since air mattress was placed.

R22 went 2 hours and 35 minutes without repositioning. On 8/3/16, during continuous observations 7:01 a.m. 9:20 a.m. R22 was not observed to be toileted. On 8/3/16 at 9:25 a.m. nursing assistant (NA)-A stated R22 was up in the wheelchair at 6:45 a.m.

On 8/3/16 at 7:01 a.m. R22 was seated in a tilt in space wheelchair. At 7:22 a.m. R22 remained seated in a tilt in space wheelchair. At 7:31 a.m. rehabilitation aide (RA)-A stood behind R22 and verbalized to the medication nurse she would move R22 back in her wheelchair. RA-A brought R22 to her room. RA-A stated R22 needed to be scooted back into her tilt in space chair. RA-A then asked R22 to lean forward and used the back of R22's blue slacks to pull her buttocks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 30 toward the back of the chair. RA-A then adjusted R22's head rest and assisted R22 in her wheelchair back to the common area by the nurses station. RA-A was not observed to offer or assist R22 with repositioning to off load pressure. At 8:05 a.m. R22 remained seated in the tilt in space wheelchair. Nursing assistant (NA)-A approached R22, stated to R22 that it was almost breakfast time. NA-A was not observed to offer 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.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 31	2 900		

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 mattress. NA-A stated R22 needed total assistance with repositioning.

On 8/3/16, at 9:29 a.m. NA-C stated R22 required total assistance with repositioning at least every 2 hours. NA-C stated R22 had skin breakdown on her buttocks within the last month or two and it had healed quickly.

On 8/3/16, at 10:40 a.m. during a follow up interview NA-A stated she had thought R22's hospice NA had assisted R22 to reposition when he was there for cares that morning. NA-A stated when R22's hospice aide would come he was responsible for repositioning. NA-A was not aware he had not done so. NA-A stated she would usually verbally communicate with the hospice aid on what was done for R22 though did not do that at this time. NA-A stated she was busy and was not able to ensure R22 was repositioned.

On 8/3/16, at 10:51 a.m. RN-A stated the usual practice for residents who received hospice care was for the NA's to verbally communicate what cares were provided for R22 prior to the hospice NA leaving. RN-A confirmed the hospice NA note revealed no cares were provided to R22 by the hospice aid. RN-A stated R22 required assistance with repositioning at least every 2 hours. RN-A stated R22 continued to be at high risk for skin breakdown and had a few "superficial" areas on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 32	2 900		

her coccyx in 6/16 which had healed by 7/16. RN-A stated she felt the superficial areas on R22's coccyx were stage one pressure ulcers because they had no depth. She indicated a pressure relieving mattress was put into place as an intervention at that time. RN-A confirmed R22's care plan was current and directed staff to assist R22 with assessed repositioning and toileting needs.

On 8/3/16, at 10:59 a.m. the director of nursing (DON) confirmed R22 was at risk for pressure ulcers. The DON stated she expected staff to follow R22's care plan for the assessed need of repositioning at least every 2 hours.

Review of facility policy and procedure titled, Positioning, revised 3/2009, 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.

R31's quarterly Minimum Data Set (MDS) dated 5/23/16, identified R31 had moderate cognitive impairment, required extensive assistance with all activities of daily living (ADLs) and had upper and lower extremity impairment. The MDS also identified R31 was always incontinent of bowel and bladder and was at risk for developing pressure ulcers and had a pressure relieving device for his chair.

R31's care plan dated 7/7/15, identified R31 had the potential for alteration in skin integrity related to impaired physical mobility, impaired skin integrity, incontinence, poor safety awareness and multiple medical problems. The care plan also identified R31 required extensive assist of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 33	2 900		

Continued From page 33

staff to turn and reposition in bed and chair every 2 hours and as necessary.

R31's care area assessment (CAA) dated 12/7/15, identified R31 was at risk for developing pressure ulcers as R31 required extensive assistance with ADLs, was always incontinent of bowel and bladder and had weight loss.

Review of R31's progress notes revealed a clinical assessment had been completed on 5/23/16, which included a BRADEN (a scale to evaluate pressure ulcer risk) score. R31's score placed him at risk for pressure ulceration and skin break down. R31 was incontinent of bowel and bladder, had a history of boils on the buttocks, groin and arm pit, was dependent upon staff for incontinence care and R31 was to be turned and repositioned every two hours.

The undated facility form titled Visual/Bedside Kardex Report which served as a nursing assistant care guide, directed staff to turn and reposition R31 every two hours when in bed and chair.

Continuous observation on 8/2/16, from 5:21 p.m. to 8:00 p.m. identified R31 had not been offered or repositioned in his chair. On 8/2/16, at 5:21 p.m. R31 was seated in the dining room at dining room table waiting for his evening meal. Resident's chair was in an upright position. At 5:47 p.m. licensed practical nurse (LPN)-B administered R31's medication. At 6:00 p.m. R31 was fed his meal by nursing assistant (NA)-H. At 6:13 p.m. NA-I broke R31's cookie in half and handed half to him. NA-I told R31 the other half of his cookie on was on his plate and walked away. At 6:29 p.m. NA-E tilted R31's wheelchair back slightly and wheeled him from the dining room to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 34	2 900		

the day area. At 6:37 p.m. R31 remained seated in the day area, asleep in his chair. At 6:48 p.m. R31 continued seated in the day area. At 7:15 p.m. NA-G pulled R31's shirt down over his belly as his lower belly was exposed. NA-G stated out loud to herself, "I think we'll have to put him to bed soon, I'll have to check with my partner and see what she says." R31's head was hanging forward and to the left, off of the head rest. At 8:00 p.m., after surveyor intervention, R31 was laid down. Observation revealed R31's buttocks were red with creases in buttocks and upper thighs. At that time, RN-B stated the redness was blanchable and the scars observed on the buttocks were from R31's history of boils.

On 8/2/16, at 7:56 p.m. NA-G stated she was was assigned to R31's care for that evening. She stated she didn't know exactly when R31 was last repositioned, but stated it was sometime before supper. NA-G stated R31 was supposed to be repositioned every 2 hours when in his chair or bed. She stated because R31 was asleep in his chair she considered that a refusal. She confirmed she did not offer R31 repositioning. She stated she didn't know if R31 was at risk for pressure ulcers because that was up to the nurses.

On 8/3/16, at 8:26 a.m. registered nurse (RN)-B confirmed R31's care plan and stated R31 should have been repositioned every 2 hours. She confirmed R31's last tissue tolerance test (TTT) (the ability of the skin and its supporting structures to endure the effects of pressure, without adverse effects) was completed on 12/3/15, and identified R31 required every 2 hour repositioning. She confirmed R31's Braden score and that R31 was at risk for developing pressure ulcers. She stated R31 had scar tissue and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 35	2 900		

history of maceration to his bottom. She confirmed the reason for every 2 hour repositioning was to offload pressure and prevent skin breakdown. She stated R31 was confused and was unable to make good decisions. She confirmed R31 required extensive to total assistance from staff for repositioning. RN-B confirmed R31 would not be able to offload pressure from his bottom while in his chair without staff assistance. She confirmed she was charge nurse last night and expected staff to offer and reposition R31 every 2 hours.

On 8/3/16, at 10:54 a.m. trained medication assistant (TMA)-B stated she felt R31 was at risk for developing pressure ulcers and stated he had a history of skin issues on his bottom. TMA-B stated current interventions to keep R31's skin intact were to reposition R31 every 2 hours and use barrier cream on his bottom. She stated R31 should be repositioned every 2 hours. She stated R31 was totally dependent on staff for bed mobility and repositioning. She stated R31's care plan directed staff to turn and reposition R31 every 2 hours.

On 8/3/16, at 11:48 a.m. NA-D stated R31 was confused and was totally dependent on staff for cares. She stated R31's care plan directed them to reposition him every 2 hours to prevent open areas. She stated she didn't think R31 was at risk for developing pressure ulcers.

On 8/3/16, at 1:10 p.m. the director of nurses (DON) stated R31 was at risk for developing pressure ulcers and required repositioning every 2 hours. The DON confirmed R31 required extensive assistance with repositioning and was totally dependent on staff for repositioning. She confirmed R31 had alterations in thought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 36 processes and impaired communication skills. She stated she would expect staff to follow the plan of care and reposition R31 every 2 hours to prevent the development of pressure ulcers. Review of facility policy and procedure titled, 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. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure pressure ulcers are appropriately prevented and/or treated as developed. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by:	2 920		8/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ____ B. WING ____	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 37 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. 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 frequently incontinent and was not on a toileting program. Review of R22's current care plan revised 7/24/16, directed facilty staff to assist R22 with toileting at least every 2 hours and to check R22's incontinent brief every 2 hours for total bowel and bladder incontinence. Review of a quarterly nursing assessment dated 7/24/16, identified R22 was frequently incontinent of bowel and bladder and required total assistance from staff with incontinence cares as directed by the care plan. R22 went 2 hours and 35 minutes without toileting. On 8/3/16, during continuous observations 7:01 a.m. 9:20 a.m. R22 was not observed to be toileted. On 8/3/16 at 9:25 a.m. nursing assistant (NA)-A stated R22 was up in the wheelchair at 6:45 a.m. On 8/3/16 at 7:01 a.m. R22 was seated in a tilt in space chair. At 7:28 a.m. R22 remained seated in a tilt in space chair near the nurses station. At 7:31 a.m. rehabilitation aide (RA)-A assisted R22	2 920	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00764	A. BUILDING: ______ 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

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2 920	Continued From page 38	2 920		

in the wheelchair to her room. Once in her room, R22 was boosted back in her wheelchair by RA-A. RA-A adjusted R22's head rest and assisted R22 in her wheelchair back to the common area by the nurses station. RA-A was not observed to check and/or change R22's incontinent brief. At 8:05 a.m. R22 remained seated in the tilt in space wheelchair. NA-A approached R22, stated to R22 that it was almost breakfast time. NA-A did not offer R22 assistance with toileting. At 8:13 a.m. licensed practical nurse (LPN)-A approached R22 and administered her medications. NA-A then took R22 to the dining room for breakfast. R22 was not offered assistance with repositioning or with checking and changing. R22 remained in the dining room until 8:54 a.m. NA-A then 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 was provided a pile of towels for folding. At 9:04 a.m. R22 remained seated in her wheelchair in the activity room. No staff had been observed to offer repositioning or check and changing. At 9:16 a.m. NA-A entered the activity room. NA-A was not observed to approach R22 or offer assistance with cares. At 9:19 a.m. AA-A approached R22, she had folded all of the towels, and asked her if she wanted to go back to her room, R22 had replied yes. AA-A then 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 with the mechanical lift. NA-A removed R22's incontinent brief which was wet with urine on the back portion of the brief.

On 8/3/16, at 9:25 a.m. NA-A stated R22 had last

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	00764	A. BUILDING: ______ 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**

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2 920	Continued From page 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.

On 8/3/16, at 9:29 a.m. NA-C stated R22 required total assistance with repositioning and checking and changing at least every 2 hours.

On 8/3/16, at 10:40 a.m. during a follow up interview NA-A stated she thought R22's hospice NA had assisted with repositioning when he was there for cares that morning. NA-A stated when R22's hospice aide was there, he was responsible for repositioning and checking and changing R22. NA-A and was not aware he had not done so. NA-A stated she would usually verbally communicate with the hospice aid on what was done for R22 though did not do it this time.

On 8/3/16, at 10:51 a.m. RN-A stated the usual practice for residents who received hospice care was for the NA's to verbally communicate what cares were provided for R22 prior to the hospice NA leaving. RN-A stated the hospice NA note revealed no cares were provided to R22 by the hospice aid. RN-A stated R22 required assistance with repositioning, checking and changing at least every 2 hours.

On 8/3/16, at 10:59 a.m. the director of nursing (DON) stated she expected staff to follow R22's care plan for her assessed need of repositioning and checking and changing at least every 2 hours.

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2 920	Continued From page 40 Review of a facility policy and procedure titled, bathroom/commode assisting, revised 11/03, revealed the policy directed facility staff that all residents were to be assisted with toileting needs per care plan. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop systems to ensure residents requiring assistance with toileting receive the necessary services. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 920		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified experience with the utilization of a catheter for 1 of 1 residents (R31)reviewed with a catheter. Findings include: R31's quarterly Minimum Data Set (MDS) dated	21805	Corrected.	8/26/16

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21805	Continued From page 41	21805		

5/23/16, identified R31 had moderate cognitive impairment, required extensive assistance with all activities of daily living (ADLs) and had upper and lower extremetity impairment. The MDS also identified R31 was always incontinent of bowel and bladder.

R31's care plan dated 7/7/16, identified R31 had an indwelling catheter placed 7/5/16, for an inability to void for extended periods of time. Staff was to monitor for odorous urine, change the Foley catheter monthly and the Foley bag every 2 weeks. The care plan failed to identify additional catheter cares for cleaning or irrigating the catheter.

On 8/1/16, at 5:00 p.m. R31 was in his wheelchair in his room in front of the TV. R31 had a catheter bag contained in a cloth bag on the side of his wheelchair. R31's bedroom had a strong, foul, concentrated urine odor.

On 8/3/16, at 7:15 a.m. R31 was observed in bed asleep with the catheter collection bag inside a cloth bag which sat on the floor next to his bed. A small silver pitcher to measure urine output and and empty urinal were on the back of R31's toilet. R31's bedroom and bathroom continued to have a strong, foul, concentrated urine odor.

On 8/3/16, at 8:26 a.m. registered nurse (RN-B) stated R31 required extensive assistance with all activities of daily living (ADLs) and was not a good decision maker. She stated she was aware of R31's urine odor and stated the urine odor started soon after R31's catheter was placed. She stated she felt there was sediment in the tube that could be causing the odor and the catheter should be gone through to check what was causing the urine odor. She stated R31's

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21805	Continued From page 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.

On 8/3/16, at 10:54 a.m. trained medication assistant (TMA)-B stated R31 was not a good decision maker as his cognition wasn't good. She stated R31 was totally dependent on staff for cares. TMA-B stated R31's urine was dark and had an odor because he didn't drink enough. She stated his urine in the bag is dark and the odor started with the initiation of the catheter. She stated when she noticed the odor the nurses would have to change it. TMA-B stated she didn't know if she told the nurse about R31's odor before today. She stated all catheters had an odor. She stated she washed R31's perineal area with soap and water, emptied R31's foley bag and confirmed she didn't rinse out the bag but closed it back up.

On 8/3/16, at 11:28 a.m. during a follow-up interview RN-B stated NA's open the catheter bag, emptied the bag and closed the bag and washed surrounding skin with soap and water. She confirmed NA's didn't rinse out the bag after it was emptied. She stated the LPN was responsible for irrigating with vinegar during the

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21805	Continued From page 43	21805		

evening or night shift. RN-B stated she didn't know where the odor was coming from and stated the odor hung in the bag and in the tubing. She stated when she noticed the odor the other day it was really bad and she should have changed his catheter at that time. She stated she talked to the night nurse the other night and had her to irrigate the tubing with plain water and stated she felt it helped.

On 8/3/16, at 11:48 a.m. NA-D stated she noticed R31's urine odor today and shelly told the nurse. She stated she washed R31's perineal area with soap and water and emptied the catheter bag. She confirmed she didn't rinse the bag after she emptied it. She stated R31 was confused and totally dependent on staff for cares. She stated she agreed with Shelly and she felt all catheters had the same odor.

On 8/3/16, at 12:25 p.m. RN-B confirmed strong urine odor in R31's bedroom and bathroom. RN confirmed the urine odor in the bathroom was from the pitcher and urinal on the back of R31's toilet which were used to measure urine from R31's catheter bag. RN lifted R31's catheter bag from the cloth bag on the floor that contained 120 cc of light brown urine and confirmed the strong urine odor was from R31's catheter bag. She stated she felt R31's urine looked pretty good as there were no "chunks in it". She stated the NA's don't rinse the bag after emptying which would have caused more odor. She stated they could have rinsed the bag after emptying, used a leg bag, and rinsed the bag every day with vinegar, used 2 different bags alternating, or try odor control drops or efferdent tablets in the bag to control R31's urine odor.

On 8/3/16, at 1:10 p.m. DON stated R31 was

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21805	Continued From page 44	21805		

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 educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.

TIME PERIOD FOR CORRECTION: Twenty (21) days.