DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 24, 2023

Administrator
Moose Lake Village
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: CCN: 245491
Cycle Start Date: May 12, 2023

Dear Administrator:

On July 7, 2023, we notified you a remedy was imposed. On August 17, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 11, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 12, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 7, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 12, 2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 11, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING _____ B. WING _____	R 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

(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 On 7/19/23, an onsite revisit was conducted to follow up on deficiencies related to a recertification survey exited on May 12, 2023. The facility was found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, yoursignature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	{F 880}		8/11/23

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

Electronically Signed | 08/16/2023

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 880}	Continued From page 1 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	{F 880}		

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{F 880}	Continued From page 2 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to perform proper hand washing observed during cares for 2 of 2 residents (R1 and R3). In addition, the facility failed to ensure proper personal protective equipment was utilized during the care of 1 of 1 residents R3 who was on precautions. Findings include: During an observation on 07/19/2023 at 11:45 a.m., R1 was positioned on his side facing the window towards licensed practical nurse (LPN)-A, R1's Foley bag was laying on the bed by his feet. Trained mediation administrator (TMA)-A started to wipe R1's buttocks when R1 started to have a bowel movement (BM) and care was stopped until R1 was finished. LPN-A provide support on R1's hip to maintain side lying position. TMA-A used wipes to clean BM from skin. TMA-A removed the dirty brief from under R1 and put it in the garbage. TMA-A went into the bathroom, removed gloves used hand sanitizer and put on a new pair glove. TMA-A positioned a clean brief and applied barrier cream to R1's buttocks.	{F 880}	F880 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia Augustana Mercy Care Center to comply with F880 To assure continued compliance, the following plan has been put into place; Regarding cited resident: The facility failed to ensure proper hand washing was performed during cares for 2 of 2 residents (R1 and R3). The facility failed to ensure proper personal protective equipment was utilized during the care of 1 of 1 residents (R3) who was on precautions. Actions taken to identify other potential residents having similar occurrences: Surveillance of ensuring that hand hygiene is being performed appropriately between glove changes, specifically in	

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{F 880}	Continued From page 3 LPN-A used a wipe and cleansed R1's front peri area. TMA-A received wipe from LPN-A, disposed of wipe, removed gloves, washed hands in the bathroom, and put new gloves on. LPN-A remained at the bedside with same gloves on. Both staff secured R1's brief, pulled R1's pants up, and got R1 positioned onto to mechanical body lift sling. LPN-A removed her gloves, did not sanitize hands, and both LPN-A and TMA-A proceeded to transfer R1 from bed to wheelchair. LPN-A then washed her hands and assisted R1 to the dining room. TMA-A sanitized hands before leaving room. On 7/19/2023 at 12:01p.m., LPN-A stated during the brief change, she had used a wipe to clean around the insertion site of R1's catheter. LPN-A stated once she was done with peri-care, she should have stopped, sanitized her hands, and put new gloves on before proceeding with care. LPN-A stated hand sanitization and a glove change should take place when going from a dirty area to a clean area. LPN-A stated she had recently received education on preventing the spread of infection and contamination that included why, when, and how to wash/sanitize hands and when to change gloves. On 07/19/2023 at 1:32 p.m., nursing assistant (NA)-A responded to a call light. The room had an isolation cart and an isolation sign outside of the door with a handwritten note: off precautions July 24. NA-A applied gloves and entered the room. R3 was in the bathroom sitting on the toilet with her feet on a mechanical stand lift. NA-A instructed R3 to stand up. R3 stood up and NA-A cleaned R3's peri area with wipes. NA-A then	{F 880}	occurrences that involved glove changes after perineal care was completed between the dates of 7/24/2023 - 8/11/2023. No additional concerns were identified during facility house surveillance. Re-education and competency testing completed with TMA-A, LPN-A and NA-A for hand hygiene between glove changes, specifically after perineal care. Surveillance and re-education completed to ensure that proper PPE was being used during observation and when entering rooms that are indicated as “on precautions” between the dates of 7/24/2023 - 8/11/2023. No additional concerns were identified during facility house surveillance. Re-education and competency testing completed with NA-A for ensuring proper PPE was used during entry to rooms indicated as “on precautions.” Measures put in place to ensure deficient practice does not recur: Staff re-education conducted on the dates of 7/24/2023 - 8/11/2023 to ensure hand hygiene is being performed appropriately and in accordance with infection control policy titled hand hygiene dated 10/2/2018, revised 10/4/2021, directed hand washing/sanitizing is necessary before and after provided care to resident, after removing gloves, after each resident contact, after handlings dressings, catheters, bed pans, specimens or urine; after touching environmental surfaces or equipment near residents, after contact with own face or mask. In addition to the re-education provided on dates of	

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{F 880}	Continued From page 4 pulled up R3's pants and had R3 sit down on the standing lift. NA-A removed one glove, did not sanitize hands, and pushed R3 to bedside. R3 stated she wanted to go to bed. NA-A stated she would get R3's bed ready and removed R3's stuffed animal from the bed and pulled the blankets down on the bed. NA-A positioned the lift over the bed and assisted R3 to a seated position on bed, and then to laying position. NA-A removed R3's glasses from her face and took R3's shoes off. NA-A elevated R3's feet on two pillows prior to pulling R3's covers up. NA-A raised her own eyeglasses on her face and then moved R3's night stand next to the bed. NA-A retrieved R3's cell phone and put it on the nightstand. NA-A removed the other glove, used hand sanitizer, and brought garbage and lift out of room. Lift was left in hall and NA-A brought garbage into dirty. On 7/19/2023 at 3:15 p.m., NA-A stated R3 was on precautions because R3 was exposed to Covid. NA-A stated she should use a face shield and gloves and indicated she had seen some staff go in with gowns. NA-A did not use a gown. NA-A indicated when she has to go in R3's room she reuses the blue surgical mask she keeps in her pocket. NA-A stated she washes her hands when she is all done with cares in a room. NA-A completed R3's peri care, pulled up R3's pants, removed one glove, and then wheeled R3 to bed. NA-A explained she touched items in R3's room with the non-gloved hand and used hand sanitizer before leaving the room. NA-A further explained she kept one glove on when she left the room to take the garbage to the dirty utility room and then cleaned both hands completely when she was done in the dirty utility room. NA-A further	{F 880}	7/24/2023 - 8/11/2023 staff were re-education on appropriate sequence and timing of performing hand hygiene following perineal care. Staff re-education conducted on the dates of 7/24/2023 - 8/11/2023 to ensure proper PPE was being used during observation and when entering rooms that are indicated as “on precautions.” In addition, re-education involved a “teach-back” method to ensure comprehension of identifying signage used and posted for “on precaution” rooms, and identifying proper PPE to be used based on type of precaution required. Effective implementation of actions will be monitored by: The IP, or designee, will further audit hand hygiene, specifically focusing on glove changes following perineal care with five audits per week on random staff for four weeks to ensure that infection control processes are being followed per guidelines. Audits to be reassessed after a four week period to determine further frequency pending outcomes to ensure F880. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The IP, or designee, will further audit proper PPE for precaution rooms with two audits per week on random staff for four weeks to ensure that infection control processes are being followed per guidelines. Audits to be reassessed after a four week period to determine further frequency pending outcomes to ensure F880. Results of these audits will be	

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{F 880}	Continued From page 5 explained she did not need to wash her hands after removing gloves after peri-care because her hands were washed prior to putting on the gloves so her hands were still clean under the gloves, but that she did clean her hand with hand sanitizer before she left the room and then completely cleaned her hands in the dirty utility room. NA-A stated she had infection prevention education recently on how to clean a Foley bag. On 7/19/2023 at 1:54 p.m., RN-A stated she has been completing random spot checks for staff hand washing. RN-A stated handwashing should occur after touching contaminated skin or wipes and before arranging pillows and touching other things. This needs to be done to keep residents and staff safe by preventing the spread of infection. On 7/19/2023 at 2:16 p.m., TMA-A stated R3 and R6 were both on isolation precautions due to exposure to Covid-19 so staff needed to use a gown, gloves, and mask before they are entering. During an observation on 7/19/2023 at 3:12 p.m., two staff were in R3 and R6's room at R6's bedside. Both staff had on gowns, gloves, and masks. On 7/19/2023 at 2:09 p.m., TMA-B stated all staff had to demonstrate handwashing in order to get signed off. The education included when to sanitize hands and change gloves. TMA-B stated you should remove your gloves and sanitize your hands after using wipes on a resident. On 7/19/2023 at 3:24 p.m., the infection preventionist (IP) stated hand washing audits and	{F 880}	reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance. Completion date for certification purposes only is: 08/11/2023	

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{F 880}	Continued From page 6 real time education had recently been done with staff. The IP stated staff had also received education on hand washing and glove use at the facility's quarterly town hall meeting. The education included: when to wash hands, how to wash hands, and indications for soap and water vs. hand sanitizer. The IP indicated staff were also educated on when to wear gloves, when to change gloves and the importance of hand sanitization after glove removal and between glove changes. The IP confirmed after performing or assisting with peri-care or a brief change, staff should stop, remove gloves, and perform hand hygiene before proceeding with care. The IP stated the facility followed the Centers for Disease Control and Prevention's (CDC) best practice recommendations and indicated proper hand sanitization and glove use was imperative to help prevent contamination and the spread of illness and serious infections like MDRO's [Multidrug-resistant organisms]. The IP stated both R3 and R6 had been exposed to Covid-19 repeatedly by a symptomatic visitor, and although both had two antigen negative Covid-19 tests, the decision had been made to implement isolation procedures because both residents had been experiencing symptoms. The IP stated the facility followed the CDC's guidelines for personal protective equipment (PPE) and indicated staff are required to put on a gown, gloves, eye protection, and a mask before entering R3 and R6's room. The IP stated it was important for staff to wear the proper PPE to prevent a possible Covid-19 outbreak in the event R3 or R6 tested positive for Covid-19 while in quarantine.	{F 880}		

DEPARTMENT OF HEALTH

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August 15, 2023

Administrator
Moose Lake Village
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: CCN: 245491
Cycle Start Date: May 12, 2023

Dear Administrator:

On June 6, 2023, we informed you that we may impose enforcement remedies.

On July 19, 2023, the Minnesota Department of Health completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) , as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is:

F880 -- S/S: D -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 12, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 12, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 12, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, 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 August 12, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Moose Lake Village will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 12, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 12, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 6, 2023

Administrator
Moose Lake Village
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: CCN: 245491
Cycle Start Date: May 12, 2023

Dear Administrator:

On May 12, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 12, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 12, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING _____ B. WING _____	C 05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/8/2023- 5/12/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed and found IN COMPLIANCE. H54912033C MN00092366 H54912034C MN00091570 H54912059C MN00087373 H54912032C MN00084251 H5491060C MN00082208 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/14/2023

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 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		7/12/23

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F 656	Continued From page 2 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive care plan was maintained to facilitate person-centered care planning for 1 of 2 residents (R27) reviewed for care planning. Findings include: R27's significant change Minimum Data Set (MDS) assessment, dated 10/5/22, indicated R27 was non-verbal, cognition was not assessed. R27 had diagnoses of epilepsy, non-traumatic intracerebral hemorrhage, arteriovenous malformation of cerebral vessels, and was dependent in all activities of daily living. Further, R27 received pain management on a regular and as needed basis including pharmacological and non-pharmacological interventions. R27's Care Area Assessment (CAA), dated 10/5/22, indicated R27 had non-verbal indicators of pain with other considerations of contractures,	F 656	F656 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia (Moose Lake Village) to comply with F656 To assure continued compliance, the following plan has been put into place; Regarding cited Resident: The facility failed to ensure a comprehensive care plan was maintained to facilitate person-centered care planning for 1 of 2 residents reviewed for care planning. Actions taken to identify other potential residents having similar occurrences:	

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F 656	Continued From page 3 immobility, and insufficient pain relief. The CAA indicated a pain problem would be carried forward to the care plan. R27's care plan lacked pain management. R27's Physician Order Report, dated 5/12/23, contained the following: -acetaminophen suppository 650 mg rectally every six hours as needed for pain or mild fever -acetaminophen 650 mg every six hours as needed for pain rated 1-5 -baclofen (a medication used to treat muscle spasms) 5 mg twice a day -hydromorphone (an opioid used to treat moderate to severe pain) 1 mg scheduled two times per day in the AM and PM -hydromorphone 2 mg every one hour as needed for pain or shortness of breath During an interview on 5/8/23 at 2:38 p.m., family member (FM)-A indicated she was unsure what R27 was getting for pain or if the facility knew R27's non-verbal indicators of pain. During an interview on 5/12/23 at 9:04 a.m., the DON stated the initial care plan templates were put in by nurse managers, and then it was a team effort to keep it updated after that. The MDS nurse also updated nursing care plans with each MDS. Care plans were updated as needed depending on the resident's condition. The DON stated an up-to-date care plan was important so you can give the right care to the resident. During an interview on 5/12/23 at 9:21 a.m., RN-C stated she was responsible for adding the nursing parts of the care plan, including putting in	F 656	Resident R27 care plan reviewed and updated to reflect appropriate pain indicators including pharmacological and non-pharmacological interventions; correction date 6/12/2023. All facility care plans reviewed to ensure proper pain indicators are monitored properly based on resident ability to communicate and their cognitive status. All facility care plans reviewed to ensure all non-pharmacological interventions are appropriate for each resident. Measures put in place to ensure deficient practice does not recur: Nurse managers re-educated regarding proper person-centered care planning. For all new admission statuses to the facility, on day 7, IDT will ensure that the care plan is properly facilitated to ensure that it is person-centered and reviewed for appropriate pain indicators based on cognitive abilities. All long-term care plans will be reviewed with their quarterly assessment reference period to ensure appropriate pain interviews based on communication abilities and cognitive status. Effective implementation of actions will be monitored by: Audits will be conducted randomly on 3 people weekly x 4 weeks, then transition to 4 people monthly randomly x 2 months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, or designee, is	

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F 656	Continued From page 4 the template on admission and making changes with resident needs. RN-C confirmed pain would be a nursing item included in the care plan. A facility memo, dated 10/14/22, with a subject line of "care plan and baseline care plan" indicated the resident care plan is constantly changing. It is to be updated routinely in the electronic record to reflect resident's current condition. The resident care plan is reviewed for accuracy, updated with quarterly MDS review and all other scheduled MDS assessments.	F 656	responsible for maintain compliance. Completion date for certification purposes only is: July 12, 2023	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor edema (a medical term for fluid trapped in the body's tissues and is graded by trained healthcare professionals on a scale of plus one to plus four, with one being the least and four being the worst) and the potential complications to the lower extremities for 1 of 1 (R58) resident reviewed. Findings include: R58's admission Minimum Data Set	F 684	F684 It is the policy of Cassia (Moose Lake Village) to comply with F684 To assure continued compliance, the following plan has been put into place; Regarding cited Resident: The facility failed to monitor edema (a medical term for fluid trapped in the body’s tissues and is graded by trained healthcare professionals on a scale of plus one to plus four, with one being the least and four being the worst) and the	7/12/23

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F 684	Continued From page 5 (MDS)assessment dated 3/23/23, included diagnoses of spastic quadriplegia, chronic obstructive pulmonary disease (COPD), and muscle spasms of the back. R58's MDS indicated he was cognitively intact and required extensive for bed mobility, transfer, locomotion, and toilet use. R58's Care Area Assessment (CAA), dated 3/23/23, for skin conditions reviewed risk factors, but did not include edema as a risk factor. R58's care plan lacked edema monitoring. R58's progress notes included the following: -3/17/23 indicated 2 plus pitting edema to left lower extremity and trace pitting edema to right lower extremity -3/20/23 indicated R58 did not feel well, claimed he was dizzy and had shortness of breath that was getting worse every day. Head of bed moderate high, unable to elevate feet of bed due to increasing shortness of breath. Referred to on-call [name or doctor] and advised to send to the emergency room. Called resident's representative, [name], but was left voicemail. Resident informed. Resident said to wait it out as he thinks he feels better as compared to what he was feeling about an hour ago. Will monitor accordingly. -4/15/23 indicated one plus bilateral lower extremity edema -4/17/23 indicated one plus bipedal edema During an interview on 5/09/23 at 9:22 a.m., R58 confirmed he had edema in both of his feet and lower legs but does not have compression socks. R58 further stated his general doctor had noted	F 684	potential complications to the lower extremities for 1 of 1 residents reviewed. Actions taken to identify other potential residents having similar occurrences: Resident R58 care plan reviewed and updated to reflect current status of edema present to bilateral lower extremities. Resident has since discharged from the facility. All facility care plans reviewed to ensure reflect current status of edema presence to lower extremities along with potential complications related to edema monitoring. Measures put in place to ensure deficient practice does not recur: Nurse managers re-educated regarding proper person-centered care planning. For all new admission statuses to the facility, on day 7, IDT will ensure that the care plan is properly facilitated to ensure that it is person-centered and reviewed for appropriateness related to potential complications related to edema monitoring/presence. All long-term care plans will be reviewed with their quarterly assessment reference period to ensure appropriateness related to potential complications related to edema monitoring/presence, if applicable. Effective implementation of actions will be monitored by: Audits will be conducted randomly on 3 people weekly x 4 weeks, then transition to 4 people monthly randomly x 2 months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.	

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F 684	Continued From page 6 the edema, but that nothing had been done. R58 was seated in wheelchair with feet in a dependent position. During an observation on 5/11/23 at 8:23 a.m., R58 was sitting in wheelchair with feet in a dependent position and verified he had edema in both lower legs. R58 elevating his feet would cause him more shortness of breath. During interview and observation on 5/11/23 at 9:10 a.m., registered nurse (RN)-B removed R58's socks. A sock line was visible on both feet. RN-B stated the right lower extremity had three plus pitting edema to the top of the right foot. RN-B stated the lower left extremity had three plus pitting edema to the top of the left foot, and the left calf had edema from the ankle to about halfway up to the knee. R58 stated this had been a concern for him and had mentioned it before but "no one else seemed concerned about it". During an interview on 5/11/23 at 9:26 a.m., the director of nursing (DON) verified that an irregularity, such as edema, would be followed up on depending on whether it had been present during the hospital stay. The DON further stated if there were a change or worsening, they would need a plan to follow up on it and that this was important because edema can lead to a lot of different things. During an interview on 5/12/23 at 9:04 a.m., the DON stated the initial care plan templates were put in by nurse managers, and then it was a team effort to keep it updated after that. The MDS nurse also updated nursing care plans with each MDS. Care plans were updated as needed depending on the resident's condition. The DON	F 684	Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance. Completion date for certification purposes only is: July 12, 2023	

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F 684	Continued From page 7 stated an up-to-date care plan was important so you can give the right care to the resident. During an interview on 5/12/23 at 9:21 a.m., RN-C stated she was responsible for adding the nursing parts of the care plan, including putting in the template on admission and making changes with resident needs. RN-C confirmed edema would be included in the care plan under risks for skin impairment along with approaches to take. A facility memo, dated 10/14/22, with a subject line of "care plan and baseline care plan" indicated the resident care plan is constantly changing. It is to be updated routinely in the electronic record to reflect resident's current condition. The resident care plan is reviewed for accuracy, updated with quarterly MDS review and all other scheduled MDS assessments	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		7/12/23

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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 690	Continued From page 8 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure catheter tubing with drainage bag was properly cleansed and stored to prevent cross contamination and infections for 1 of 2 residents (R42) reviewed for catheters. Findings include: R42's Quarterly Minimum Data Set (MDS) assessment dated 3/23/23, indicated R42 had moderately impaired cognition. Needed extensive assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene, and had an indwelling catheter. R42's care plan reviewed 4/5/23, indicated R42 had a foley catheter related to having a	F 690	F690 It is the policy of Cassia (Moose Lake Village) to comply with F690 To assure continued compliance, the following plan has been put into place; Regarding cited Resident: The facility failed to ensure catheter tubing with drainage bag was properly cleansed and stored to prevent cross contamination and infections for 1 of 2 residents reviewed with catheters. Actions taken to identify other potential residents having similar occurrences: The facility reviewed all other drainage bags and found no other concerns. All other drainage bags were noted to not be interchangeable; R42 having the only preference to interchange his catheter drainage bag.	

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	245491	A. BUILDING _____ B. WING _____	C 05/12/2023

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F 690	Continued From page 9 neurogenic bladder and had previously failed trail removals. R42's face sheet printed 5/11/23, indicated R42's had the following diagnoses Parkinson's Disease, palliative care, dementia, major depressive disorder, anxiety, benign prostatic hyperplasia, obstructive and reflux uropathy, mixed incontinence, and neuromuscular dysfunction of bladder. During observation on 5/10/23 at 8:29 a.m., R42's bathroom had an undated catheter drainage bag hanging on a bar next to the left side of the toilet. The tip of the tubing was resting on the wall uncovered. During an interview on 5/10/23 at 8:34 a.m., nursing assistant (NA)-B stated nursing assistants clean the catheter bags with regular water and then they get store in bins in each resident's bathrooms. On 5/10/23 at 8:38 a.m., NA-C stated if the catheter bags need to be rinsed out with more than water the nurse would do that. If it is just a water rinse a nursing assistant can do that. R42's catheter bags are stored over the bar by the toilet in his bathroom. On 5/10/23 at 8:43 a.m., trained medication assistant (TMA)-A stated the nursing assistants are supposed to rinse the catheter bags with warm water and either place them in the bin or hang them over the bar in the bathroom next to the toilet. During observation on 5/11/23 at 10:02 a.m., R42's storage bin in his bathroom had an	F 690	Measures put in place to ensure deficient practice does not recur: Non licensed and licensed staff were re-education provided on dates, 5/15/2023 and the dates of all staff mandatory meetings, 7/5/2023, 7/6/2023 and 7/12/2023 to ensure proper knowledge and awareness of need for properly cleansed and stored catheter drainage bags. Effective implementation of actions will be monitored by: Due to resident R42's discharge, and resident R42 found to be the only resident with a preference to interchange his catheter drainage bag; no forth audits will be conducted regarding the proper storage of catheter drainage bags. However, facility will monitor quarterly to ensure that all drainage bags are still noted to not be a preference to be interchangeable, and monitor to ensure that if the preference is preferred to ensure proper cleansing and storage of catheter drainage bag randomly through weekly audits. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance. Completion date for certification purposes only is: July 12, 2023	

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F 690	Continued From page 10 undated catheter drainage bag with yellow liquid in it. The catheter bag tubing was touching the outside of the bag uncovered. During an interview on 5/11/23 at 10:04 a.m., NA-A stated they would ran water through the catheter bag and cleansed both sides of the tubing with an alcohol wipe then place the catheter bag in R42's bin today. On 5/11/23 at 10:12 a.m., registered nurse (RN)-A verified R42's catheter bag had yellow liquid in it and that the tubing was uncovered. RN-A stated there should be a cover on the tubing and there should not be urine in the catheter bag. RN-A said they need to use an alcohol wipe to both sides of the tubing, rinse the bag with clear water, and allow to air dry and over the railing in the bathroom. On 5/11/2023 at 10:35 a.m., NA-D stated staff are supposed to rinse the catheter bag with vinegar and then hang it on the bar on the resident's side of the bathroom. On 5/11/2023 at 11:07 a.m., the director of nursing (DON) stated she expects staff to follow what the policy says when it comes to catheter and leg bags. The facility policy titled Urinary Indwelling Catheter Insertion and Management reviewed 4/14/2023, indicated the facility would immediately cover the end of the catheter bag tubing with a sterile cap or alcohol swab and packet. The facility would place collection bag and tubing in towel on bottom shelf of storage location.	F 690		

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F 880	Continued From page 11	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		7/12/23

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F 880	Continued From page 12 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation the facility failed to ensure proper hand washing/sanitization occurred for 1 of 1 resident (R)50 observed during cares. Finding include: During an observation on 5/10/23 at 9:40 a.m., nursing assistant (NA)-F entered R50's room and	F 880	F880 It is the policy of Cassia (Moose Lake Village) to comply with F880 To assure continued compliance, the following plan has been put into place; Regarding cited Resident: The facility failed to ensure proper hand washing/sanitization occurred for 1 of 1 residents observed during cares.	

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F 880	Continued From page 13 applied gloves. NA-E was already in the room and had R50's full body lift sling hooked up and ready for transfer. R50 was lowered to bed and foley catheter was placed on top of bed by right foot. NA-F removed R50's shoes. NA-E removed brace off R50's upper body. NA-F and NA-E rolled R50 away from NA-E's body towards window and NA-F. NA-F held R50 towards window on left side. Bottoms were lowered and NA-E cleaned peri area of stool, removed soiled brief, and placed new brief behind R50. Resident rolled back towards NA-E. to flat position. NA-F pulled new brief into place and secured tabs. With same gloves on NA-F rearranged R50's shirt for him. NA-E removed gloves, did not hand sanitize, and proceeded to helped NA-F get R50 positioned in bed. While still wearing the same gloves, NA-F handled the foley bag, and then put a new pillowcase on R50's pillow. NA-E did not hand sanitize, placed new gloves on, emptied foley, placed foley in dignity bag, brought graduated cylinder to bathroom, emptied urine in toilet, and then washed hands at sink. NA-F still wearing same gloves, gave call light to R50. NA-F and NA-E reposition R50 on to left side. NA-F went into drawer in room, retrieved a dressing and placed it over small open red area on R50's leg. NA-F then removed gloves and proceeded to wipe down the transfer lift with sanitizing wipes. NA-F then sanitized hands before leaving the room. NA-E sanitized hands prior to leaving the room. On 5/10/23 at 12:49 p.m., NA-F stated the clean field was broken after touching the foley bag and agreed hands should have been sanitized. NA-F touched R46's skin during brief change and said	F 880	Actions taken to identify other potential residents having similar occurrences: Surveillance of ensuring that hand hygiene is being performed appropriately for the required timeframe between glove changes during cares. No additional concerns were identified during facility house surveillance. Measures put in place to ensure deficient practice does not recur: Hand Hygiene policy reviewed and current as dated 3/14/2019, revised 3/20/2023. All staff re-education on dates of all staff mandatory meetings, 7/5/2023, 7/6/2023 and 7/12/2023 to ensure hand hygiene is being performed appropriately and in accordance with infection control policy titled hand hygiene dated 3/14/2019, revised 3/20/2023 directed hand washing/sanitizing is necessary before and after provided care to resident and after removing gloves. Effective implementation of actions will be monitored by: The clinical managers, or designee will further audit hand hygiene weekly randomly three people for x 3 weeks, then transition to one person weekly x 4 weeks to ensure that infection control processes are being followed per guidelines. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance. Completion date for certification purposes	

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F 880	Continued From page 14 would normally have sanitized hands. Hand sanitize should have been used after helping with a brief change and before helping with repositioning or giving the resident a remote. NA-F stated they received training and education on hand sanitizing/washing, and personal protective equipment (PPE) for infection prevention. During an interview on 5/12/23 at 10:38 a.m., the infection preventionist (IP) and the director of nursing (DON). The IP stated glove removal and hand sanitization would be required after performing peri-care, assisting during peri care (skin touch/holding the resident on side), or after touching a foley bag. IP and DON stated they would expect staff to stop, remove gloves and perform hand sanitization after participating in peri-care, and prior to proceeding with repositioning resident, and handling items in the room. DON and IP indicated hand washing is assigned through Relias (computer-based education), and staff must complete an annual check off and hand washing competency. In addition, the facility conducts on going hand washing audits with immediate on the spot staff education as needed.	F 880	only is: July 12, 2023	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/11/2023. At the time of this survey, Moose Lake Village was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/14/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Moose Lake Village is a 1-story building with small partial basement. The original building was constructed in 1964 and additions constructed in 1968 and 1977, all of Type II(111 construction). A single story hospital adjoins the nursing home and is separated by a 4 hour wall. To the south a single story type V(111) assisted living facility also adjoins and is separated by 4 hour construction with a 3 hour rated, self closing door. Therefore, the nursing home was inspected as one building.	K 000		

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K 000	Continued From page 2 The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 95 beds and had a census of 80 at the time of the survey.	K 000		
K 226 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.4.5.1 This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/11/2023 at 13:09PM, it was revealed by observation that exterior Emergency Door #20 failed to open when 30lbs of pressure was	K 226	K226 Horizontal Exits It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. On 5/12/23 site maintenance made the needed adjustments to Emergency Door #20 that had failed to open when 30 lbs. of pressure were applied has been corrected.	7/12/23

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K 226	Continued From page 3 applied. An interview with Director of Environmental Services verified these deficient findings at the time of discovery.	K 226	This door and a random sampling of other emergency doors will be audited weekly for the next three (3) months to ensure compliance and any necessary adjustments will be made to continue to allow this and other emergency doors to function in accordance with Life Safety Codes. All findings will be brought to the QAPI Committee for review and further direction, whether facility needs to continue audits or not to ensure compliance. The Director of Environmental Services will be responsible for these corrective actions.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient practice could reduce the illumination of the exits and affect an undetermined amount of residents, staff and visitors. This deficient practice could have a patterned impact on the residents within	K 281	K281 Illumination of Means of Egress It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. 1) Exterior light for door #20, Electrician scheduled to install additional bulb to	7/12/23

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K 281	Continued From page 4 the facility. Findings include: 1) On 05/11/2023 at 13:09PM, it was revealed by observation that the exterior lights for door # 20 of the exit discharges had only one bulb for illumination and was not back up with emergency generator power. At the time of discovery the Director of Environmental Services stated "he did not know" the lights generator back up status. 2) On 05/11/2023 at 13:26PM, it was revealed by observation that the exterior lights for door # 18 of the exit discharges had only one bulb for illumination. An interview with the Director Environmental Services verified these deficient findings at the time of discovery.	K 281	comply with the lighting/illumination of this area. A proposal for this work has been obtained with a scheduled completion date on or before 07/12/2023. Corrective action will bring this light into compliance with Life Safety Codes and is under Emergency Generator Backup Power. 2) Exterior light for door #18, Electrician scheduled to install additional bulb to comply with the lighting/illumination of this area. A proposal for this work has been obtained with a scheduled completion date on or before 07/12/2023. Corrective action will bring this light into compliance with Life Safety Codes and is under Emergency Generator Backup Power. Audit of these exterior lights and other emergency egress lighting systems will be performed weekly for the next three (3) months to ensure ongoing compliance The Director of Environmental Services will be responsible for these corrective actions.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code sections	K 291	K291 Emergency Lighting It is the policy of Moose Lake Village to be	5/15/23

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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
K 291	Continued From page 5 19.2.9.1 and 7.9.1.3. This deficient practice could have a patterned impact on the residents within the facility. Findings include: On 05/11/2023 at 11:14AM, it was revealed by observation that the facility failed to conduct the annual 90 minute required Emergency Lighting test. An interview with the Director or Environmental Serviced verified this deficient finding at the time of discovery.	K 291	in compliance with Fire Protection and physical environments requirements. The Annual Emergency Lighting Test was conducted for 90 minutes during the Monthly Inspection of Extinguishers and Emergency Lights on 05/15/2023. Routine maintenance system will be updated to reflect the month of May as the usual date/time of this annual inspection from this date forward to ensure ongoing compliance with the annual requirement. The Director of Environmental Services will be responsible for these corrective actions.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: The building is divide Based on observation and staff interview, the facility failed to maintain and/or install proper exit signage under NFPA 101 (2012 edition), Life Safety Code sections 19.2.10.1, 7.10.1.2.2, 7.10.83, 7.10.8.31 and 7.10.8.3.2. This deficient practice could have a patterned impact on the residents within the facility.	K 293	K293 Exit Signage It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. “Not an Exit” signage has been installed	6/8/23

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	245491	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/11/2023**

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K 293	Continued From page 6 Findings include: On 05/11/2023 at 13:15PM, it was revealed by observation that the door leading to the Courtyard in the SCU Unit was missing a "NO EXIT" sign. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 293	by maintenance on 06/08/2023. Audits of this door will be conducted during the annual door audit to ensure that signage remains on door. The Director of Environmental Services will be responsible for these corrective actions.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		5/15/23

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	245491	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/11/2023**

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K 321	Continued From page 7 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/11/2023 at 10:11AM, it was revealed by observation that there was hold open device on storage room 211 and 276 both located on the facilities lower level. An interview with Director of Environmental Services verified these deficient findings at the time of discovery	K 321	K321 Hazardous Areas-Enclosure It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. Maintenance removed all hold open devices from door #211 and 276 on the lower level of the property on 05/15/2023. All other doors were audited and no other concerns were identified. Audits of doors will be performed weekly for the next three months to ensure compliance with this Life Safety Code. The Director of Environmental Services will be responsible for these corrective actions.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders,	K 341		5/15/23

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K 341	Continued From page 8 and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of NFPA 101 (2012 edition), The Life Safety Code, sections 9.6 and 19.3.4.1, as well as NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 17.7.4.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 05/11/2023 at 13:45PM, observation revealed, that the smoke detector in the loading dock area was installed 12 inches from a HVAC vent diffuser, and is within the direct air flow from that vent . An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 341	K341 Fire Alarm System - Installation It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. On May 15th, 2023 maintenance relocated the smoke head away from the HVAC vent a distance of greater than twenty-four (24) inches to be in compliance with Life Safety Code. There are no other smoke heads near the HVAC vents in this facility. The Director of Environmental Services will be responsible for these corrective actions.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		5/11/23

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K 345	Continued From page 9 Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: FIRE SAFETY Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/11/2023 at 11:29AM, it was revealed by a review of available documentation that the annual fire alarm sensitivity testing documentation was not available at the time of the survey. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 345	K345 Fire Alarm System – Testing and Maintenance It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. The Annual Fire Alarm Sensitivity Testing Report was completed by Per-Mar Security Services on February 21st, 2023. This completed form/test was emailed to State Fire Marshal to verify compliance on 5/11/2023. The form/test is available for inspection upon request. All required fire documentation is audited every 12 months to ensure ongoing compliance. The Director of Environmental Services will be responsible for these corrective actions.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		5/12/23

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K 353	Continued From page 10 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 05/11/2023, between 10:13AM and 13:36PM, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in: 1) In room #276 2) Kitchen dish washing room An interview with the Director of Environmental	K 353	K353 Sprinkler System – Maintenance and Testing It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. 1) Nurse Storage Room #276, items removed from areas above the 18” ceiling clearance distance on 5/12/2023 by maintenance. Visual inspections of this areas will be completed during restocking of supplies weekly to ensure future compliance. 2) Items removed from Kitchen/dish/wash area by Dietary Manager on 5/12/2023, so that items are a distance of 18” from ceiling. All staff education will be done on 07/05/2023, 07/06/2023 and 07/12/2023 and this citation will be included.	

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K 353	Continued From page 11 Services verified these deficient findings at the time of discovery.	K 353	Audit will be completed weekly over the next three (3) months to ensure compliance of this policy is met. The Director of Environmental Services will be responsible for these corrective actions.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/11/2023 at 11:16AM, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with Director of Environmental Services verified this deficient finding at the time of discovery.	K 355	K355 Portable Fire Extinguishers It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. Site received detailed documentation from the vendor/contractor that performed this annual inspection in November of 2022, and has the current documentation on site to comply with this life safety requirement. Documentation available upon request. All required fire extinguisher documentation is audited every 12 months to ensure ongoing compliance. The Director of Environmental Services will be responsible for these corrective actions.	5/15/23

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K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		7/12/23

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K 363	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient practice could have a patterned impact on the residents within the facility. Findings include: 1) On 05/11/2023 at 0935AM, it was revealed by observation that the door to the HUK Office (North Nurse Station 400 wall) did not latch, was missing fire rating and had a mechanical hold open device that was not connected to the fire alarm system. 2) On 05/11/2023 at 0935AM, it was revealed by observation that the door to patient room 202 did not latch. 3) On 05/11/2023 at 0935AM, it was revealed by observation that the door to the Landry room was taped open as to not allow the door to self latch. An interview with Director of Environmental Services verified this deficient finding at the time of discovery.	K 363	K363 Corridor – Doors It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. 1) HUC Office (North Nurse Station 400 Wall) latch adjustment to be done by maintenance prior to July 12th, 2023 to ensure that door latches properly. Mechanical hold open device removed by maintenance to comply with life safety code. Verification of fire rating of this door is being done with vendor and necessary labels will be added to door or if fire rating cannot be verified, signed proposal for new fire door will be in place before July 12, 2023. 2) Patient/Resident room #202, door to be adjusted by maintenance prior to July 12th, 2023 to be in compliance with life safety code. 3) Laundry Area/Soiled Linen loading dock side door tape removed on 5/11/2023. Handle removed and a non-locking handle has been installed by maintenance on 6/13/2023 to create ease of access for laundry vendor to comply with life safety code. Audits of doors will be done weekly for the next three (3) months to ensure that these doors function and close properly and are labelled correctly.	

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K 363	Continued From page 14	K 363	The Director of Environmental Services will be responsible for these corrective actions.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. This deficient practice could have a patterned impact on the residents within the facility. Findings include: 1) On 05/11/2023 at 09:33AM, it was revealed by observation that there were three (3) penetration running from one smoke compartment to another above North Nurse Station in 400 wall. 2) On 05/11/2023 at 12:05AM, it was revealed by observation that there was a penetration running	K 372	K372 Subdivision of Building Spaces It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. 1) North Nurse Station 400 Wall, 3 penetrations to be filled by maintenance prior to June 30h, 2023. 2) Kenwood Place Wall, 1 penetration to be filled by maintenance prior to June 30th, 2023. 3) SCU Day Room penetration above the T.V. area to be filled by maintenance prior to June 30th, 2023. 4) North Wall Room 216, 3 penetrations to be filled by maintenance prior to June	6/30/23

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K 372	Continued From page 15 from one smoke compartment to another above door to Kenwood Place. 3) On 05/11/2023 at 12:05AM, it was revealed by observation that there was a penetration running from one smoke compartment to another above television in SCU Unit Day Room. 4) On 05/11/2023 at 09:33AM, it was revealed by observation that there were three (3) penetration running from one smoke compartment to another above north wall Room 216. An interview with Director of Environmental Services verified these deficient findings at the time of discovery	K 372	30h, 2023. The Environmental Director will ensure vendors doing work on any smoke barriers fill penetrations where work was completed, if any, before they leave the facility and will be inspected by the Environmental Services Director to ensure compliance with the code. The Director of Environmental Services will be responsible for these corrective actions.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition),	K 511	K511 Utilities – Gas and Electric It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements.	5/11/23

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K 511	Continued From page 16 Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 05/11/2023 at 12:42PM, it was revealed by observation that the electrical panel located in the 400 wing was not locked. 2) On 05/11/2023, at 13:10PM, it was revealed by observation that the electrical panels located in the 200 wing were not locked. 3) On 05/11/2023 at 13:14PM, it was revealed by observation that the electrical panels located in the SCU wing were not locked. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 511	1) 400 Wing panel secured by maintenance on 5/11/2023. 2) 200 Wing panel secured by maintenance on 5/11/2023. 3) SCU panel secured by maintenance on 5/11/2023. An Audit of this areas will be completed by the Director of Environmental Services weekly for the next three (3) months to ensure that these areas are secure/locked in compliance with life safety code. The Director of Environmental Services will be responsible for these corrective actions.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2,	K 711		6/1/23

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	245491	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/11/2023**

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MOOSE LAKE VILLAGE	**710 SOUTH KENWOOD AVENUE** **MOOSE LAKE, MN 55767**

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K 711	Continued From page 17 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide periodical training to staff on duties under the Evacuation and Relocation Plan plan per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/11/2023, at 09:54AM, it was revealed by interview with the Director of Environmental Services, were he stated he was unfamiliar with the locations of all the smoke barriers and did not receive training on those locations. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 711	K711 Evacuation and Relocation Plan It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. Upon hire and annually, all staff receive education on fire safety, which includes evacuation and fire relocation plans. Director of Environmental Services now has complete knowledge of the building layout and compliance with safety codes. Basic building structure and orientation has been completed at the site. Building layout will be included on Environmental Service Director orientation checklist. The Administrator will be responsible for the orientation and checklist verification.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible	K 712		6/13/23

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K 712	Continued From page 18 alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/11/2023 at 11:10AM, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: 1) first shift 03/22/2023 at 08:00AM and 06/29/2022 at 08:30AM. 2) second shift 01/10/2023 at 15:00PM and 04/24/2023 at 15:00PM 3) third shift 11/15/2022 at 05:30 and 02/15/2023 at 05:30PM An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 712	K712 Fire Drills It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. Effective immediately adjustments to the times have been made to ensure that at least one hour and fifteen minutes are the time frame difference between scheduled drills. Fire Drill documentation will be reviewed and audited at the quarterly Safety Committee meetings for appropriateness of timing and then reported at the QAPI Meetings for further direction. The Director of Environmental Services will be responsible for these corrective actions.	
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701.	K 753		5/11/23

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K 753	Continued From page 19 o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to prohibit combustible decorations per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.5.6 and 19.7.5.6 (4). These deficient findings could have a patterned on the residents within the facility. Findings include: On 05/11/2023, at 09:41AM, it was revealed by observation that a candle was located on a wooden shelf in the North Nursing Station along the 400 Wing wall. An interview with Director of Environmental Services verified these deficient findings at the time of discovery	K 753	K753 Combustible Decorations It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. The candle on the shelf in the North Station was removed immediately on 05/11/2023. An audit of the facility revealed no further candles or combustibles present. All staff will be educated on 07/05/2023, 07/06/2023 and 07/12/2023 to not display any combustible items anywhere on site. Audits of Combustibles will be performed monthly for the next three months for compliance to this life safety code. The Director of Environmental Services will be responsible for these corrective actions.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		5/31/23

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K 914	Continued From page 20 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/11/2023 at 11:32AM, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey.	K 914	K914 Electrical Systems – Maintenance and Testing It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. This annual inspection was in process at the time of this inspection and has since been completed and filled in the binder. It is available for review by State Fire Marshal upon follow up site visit. The routine maintenance system was	

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K 914	Continued From page 21 An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 914	updated to ensure an every 12 month cycle beginning in May of 2023. All required fire documentation is audited every 12 months to ensure ongoing compliance. The Director of Environmental Services will be responsible for these corrective actions.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		7/12/23

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K 918	Continued From page 22 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 05/11/2023, at 14:00PM, it was revealed by observation that the Emergency Generator Alarm Annunciator Panel was blocked behand the television in the Day Room on the SCU Unit wing. 2) On 05/11/2023, at 14:00PM, it was revealed by observation that the Emergency Generator Alarm Annunciator Panel was not located location readily observed by operating personnel at a regular work station An interview with Director of Environmental Services verified these deficient findings at the time of discovery.	K 918	K918 Electrical Systems It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. Remote Monitoring or Relocation of this panel to be completed by July 12th, 2023 and a signed proposal will be in place for completion of the work. Director of Environmental Services is responsible for making sure this work is complete and the facility remains in ongoing compliance.	
K 927 SS=E	Gas Equipment - Transfilling Cylinders	K 927		7/12/23

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K 927	Continued From page 23 CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen transfilling rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.3.1 (1). This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1) On 05/11/2023 at 13:43, it was revealed by observation that the nonactive door to the oxygen trans-fill room on the Loading Dock would not automatically latch and was missing the required self-closing device. 2) On 05/11/2023 at 13:43, it was revealed by observation that the doors to the oxygen trans-fill room on the Loading Dock were missing fire rating tags. An interview with the Director of Environmental Services verified this deficient finding at the time	K 927	K927 Gas Equipment – Transfilling Cylinders It is the policy of Moose Lake Village to be in compliance with Fire Protection and physical environments requirements. The door will be verified for fire rating, proper labelling will be applied and self-closing and automatically latching devices will be installed by July 12th, 2023. Audits of doors will be done weekly for the next three (3) months to ensure that these doors function and close properly and are labelled correctly. The Director of Environmental Services will be responsible for these corrective actions.	

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K 927	Continued From page 24 of discovery.	K 927		