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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** ID: O3YC

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** Facility ID: 00764

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/27/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Superviosr 08/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/28/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**08/09/2018**
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

CMS Certification Number (CCN): 245569

August 28, 2018

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

Dear Administrator:

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

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

Effective August 6, 2018 the above facility is recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 28, 2018

Administrator
Halstad Living Center
133 Fourth Avenue East
Halstad, MN 56548

RE: Project Number S5569030

Dear Administrator:

On July 23, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 12, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 27, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 13, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 12, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 6, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 12, 2018, effective August 6, 2018 and therefore remedies outlined in our letter to you dated July 23, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O3YC

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00764

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

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

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

4. TYPE OF ACTION: **2** (L8)

| | |
|---|---|
| **1. Initial** | **2. Recertification** |
| **3. Termination** | **4. CHOW** |
| **5. Validation** | **6. Complaint** |
| **7. On-Site Visit** | **9. Other** |
| **8. Full Survey After Complaint** | |

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/12/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Beth Nowling, HFE NE II 08/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 08/08/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
July 23, 2018

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

RE: Project Number S5569030

Dear Ms. Nelson:

On July 12, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the

attached deficiencies.

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

## DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

## OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 21, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 21, 2018 the following remedy will be imposed:

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

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 12, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 12, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

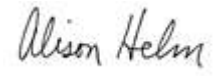
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245569 | A. BUILDING _____ B. WING _____ | 07/12/2018 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on July 9, 2018 through July 12, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 7/9/18, through 7/12/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>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 in accordance with your verification. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. | F 550 | | 7/26/18 |

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

Electronically Signed | 07/27/2018

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245569 | A. BUILDING _____ B. WING _____ | 07/12/2018 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 1<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 1 resident (R18) who was reviewed for tracheal care. | F 550 | F550 DIGNITY<br>R18 will have his clothing protector checked and changed for soiling due to respiratory secretions from his | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245569 | A. BUILDING _____ B. WING _____ | 07/12/2018 |

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

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| F 550 | Continued From page 2<br><br>Findings include:<br><br>R18's quarterly Minimum Data Set (MDS), dated 5/15/18, identified R18 had diagnoses which included dementia, Parkinson's, dysphasia (difficulty swallowing) and encounter for attention to tracheostomy(artifical opening into the trachea through the neck.) R18's MDS identified R18 had both short term and long term memory problems and had severely impaired cognitive skills for daily decision making. Further, The MDS indicated R18 required total assistance from staff with activities of daily living (ADL's) and received tracheostomy care.<br><br>R18's care plan revised on 5/25/18, identified R18 had a potential for ineffective airway clearance related to tracheal secretions, dysphagia and coronary obstructive pulmonary disease (COPD). The care plan listed various interventions which included nursing to monitor respiratory status, sputum, oxygen saturation levels every shift and as needed. R18's also had an ADL self care deficit related limited mobility, history of stroke, Parkinson's and cognitive impairment. The care plan listed various interventions which included totally dependent on two staff for personal hygiene and one staff for oral care.<br><br>During observations on 7/11/18 at 7:13 a.m. R18 was seated in his wheelchair out in the commons area next to the nurses station. R18 had a multi-colored clothing protector draped across his chest area and tied behind his neck. R18 had a tracheostomy with copious amounts of thick, yellow sputum hanging approximately three inches from his tracheostomy site onto his clothing protector. There was several other | F 550 | tracheostomy every ½ hour an as needed.<br>All residents with tracheostomies will be assessed for respiratory secretions and will be placed on a schedule for changing clothing protectors as needed.<br>All nursing staff will be educated on providing dignified care to patients with tracheostomies who have secretions on 7-26-18; 7-27-18 and 7-30-18.<br>The policy and procedure for dignity was reviewed.<br>R18 and any other resident with a tracheostomy will be audited for soiled clothing protectors randomly on each shift for 2 weeks, then randomly three days per week on various shifts ongoing. The QA committee will evaluate the results of the audits and will determine further audit schedules at their regular meeting on 9-15-18.<br>The Director of Nursing or designee is responsible. | |

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residents seated in the commons area next to R18 and staff members walking by the commons area, and two nurses passing medications in the commons area.
-at 7:24 a.m. R18 remained seated in his wheelchair out in the commons area next to the nurses station with other residents seated in the area. Copious amounts of thick, yellow sputum continued to be present hanging approximately three inches from his tracheostomy site onto his clothing protector.
-at 7:44 a.m. R18 remained seated in his wheelchair with several other residents in the commons area next to the nurses station with copious amounts of thick, yellow sputum hanging approximately three inches from his tracheostomy site onto his clothing protector.
-at 8:03 a.m. trained medication aid (TMA)-A and nursing assistant (NA)-A wheeled R18 back to his room, TMA-A removed the soiled multi-colored clothing protector from R18's chest area with copious amounts of thick, yellow sputum and placed a clean multi- colored clothing protector across R18's chest area and tied it behind his neck. TMA-A proceeded to shave R18's face while NA-A walked into the bathroom, gloved both hands and proceeded to check R18's brief for incontinence.
-at 8:07 a.m. TMA-A wheeled R18 back out to the commons area by the nurses station.

During observations on 7/12/18 at 8:29 a.m. R18 was seated in his wheelchair out in the commons area next to the nurses station. R18 had a multi-colored clothing protector draped across his chest area and tied behind his neck. R18 had copious amounts of thick, yellow sputum on his clothing protector. There was several other residents seated in the commons area near and

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next to R18, and several staff members walking by the commons area, two nurses passing medications in the commons area.
-at 8:33 a.m. TMA-A approached R18 while he was seated in his wheelchair in the commons area with the other residents and wheeled him back to his room. TMA-A gloved, removed the soiled clothing protector from R18's chest area, place a clean multi- colored clothing protector across his chest area and tied it behind his neck. TMA-A proceeded to wheel R18 back out to the commons area by the nurses station.

On 7/12/18 at 8:34 a.m. TMA-A confirmed R18 had a lot of phlegm on his clothing and indicated it happens quite a bit. TMA-A indicated when staff noticed the phlegm, they would bring him back to his room and change his clothing protector.

On 7/11/18 at 1:25 p.m. licensed practical nurse (LPN)-B confirmed R18 needed total assistance from staff with ADL's and indicated she expected staff to change R18's clothing protector when soiled. LPN-B indicated she felt other residents and visitors might be uncomfortable seeing the large amount of sputum/phlegm on R18's clothing protector. LPN-B indicated she felt R18 would be embarrassed if he knew he had sputum/phlegm on his clothing protector.

On 7/12/18 AT 8:39 a.m. LPN-A confirmed R18 needed total assistance from staff with ADL's and always had lots of secretions from his tracheal site. LPN-A indicated staff should be monitoring R18 more and indicated staff were to change R18's clothing protector when soiled. LPN-A indicated she had been thinking about this and indicated dignity was the big thing with R18's secretions and staff need to be aware of it.

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| F 550 | Continued From page 5<br><br>On 7/12/18 at 8:48 a.m. director of nursing (DON) confirmed R18 needed total assistance from staff with ADL's and indicated staff clean R18's sputum on his clothing protector when they see it.<br><br>Review of facility policy titled, Dignity revised on 2/2017, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. | F 550 | | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg<br>CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 2 (R22) residents reviewed for a decline activities of daily living (ADL's).<br><br>Findings include: | F 637 | F637 COMPREHENSIVE ASSESSMENT AFTER A SIGNIFICANT CHANGE<br>R22 had a comprehensive significant change assessment completed on 7-17-18.<br>The MDS Coordinator will complete an audit on all residents most current full MDS to unsure there were no significant changes. Audit will be completed by 8-10-18. | 8/2/18 |

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| F 637 | Continued From page 6<br>R22's quarterly Minimum Data Set (MDS) dated 3/6/18, identified R22 had severe cognitive impairment and had diagnoses which included Alzheimer's, dementia and Parkinson's. The MDS identified R22 required extensive assistance of two staff for ADL's, bed mobility, transfers, dressing, toileting, personal hygiene and extensive assistance of one staff for eating. The MDS identified R22 required total assistance of one staff for locomotion on and off the unit, did not ambulate and required total assistance of two staff for bathing. The MDS revealed R22's weight at the time of the MDS was 149 pounds (lbs.) The MDS also identified R22 was frequently incontinent of bowel and bladder and was not on a toileting program.<br><br>R28's quarterly MDS dated 5/29/18, identified R22 had severe cognitive impairment and had diagnoses which included Alzheimer's, dementia and Parkinson's. The MDS identified R22 was totally dependent of two staff for with ADL's for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and totally dependent of one staff for eating, locomotion on and off the unit and did not ambulate. The MDS revealed R22's weight at the time of the MDS was 139 lbs, a 10 lb weight loss since R28's last MDS. The MDS also identified R22 was always incontinent of bowel and bladder and was not on a toileting program.<br><br>Review of R22's quarterly MDS assessments indicated R22 had a 10 lb weight loss, required increase need for staff assistance in bed mobility, transfers, dressing, toileting, personal hygiene and eating. The assessment further indicated R22 had a decline in bowel and bladder incontinence from frequently to always | F 637 | All residents will be reviewed for a significant change in IDT meeting Monday-Friday with each quarterly and annual MDS assessment. A record of this daily review will be kept for auditing purposes.<br>The members of the IDT team will be provided education on significant change identification and the process to follow on 8-2-18.<br>An audit of each resident who is due for a quarterly or annual MDS will be audited for a significant change with their MDS schedule ongoing by the MDS Coordinator. A record of the IDT review will be used for auditing.<br>The results of the audits will be reported to the QA committee at their regular meeting on 9-15-18 and will determine further audit schedules.<br>The Director of Nursing or designee is responsible. | |

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| F 637 | Continued From page 7<br>incontinent.<br><br>On 7/12/18 at 10:24 a.m. trained medication aid (TMA)-A she stated R22 required total assistance from staff for all of his ADL's and indicated R22 had not really changed except for he used to feed himself on the evening shift at times.<br><br>On 7/12/18 at 10:35 a.m. licensed practical nurse (LPN)-A confirmed R22 required total assistance from staff for all of his ADL's, used a full mechanical lift for transfers and used to require extensive assistance of two staff with cares.<br><br>On 7/12/18 sat 10:52 a.m. the facility MDS coordinator (MDSC)-A confirmed she had completed both of R22's aforementioned MDS's. The MDSC-A indicated R22 would fluctuate from extensive assistance to total assistance of two staff. The MDSC-A indicated after review R22 would have had a significant change in urinary incontinence and ADL's and indicated a significant change MDS should have been done. The MDSC-A indicated that she had made a mistake and R22 had two or more care area changes in a group and missed it. The MDSC-A indicated she followed the MDS guide/bible meaning resident assessment instrument (RAI manual).<br><br>On 7/12/18 at 11:14 a.m. director of nursing (DON) indicated that she relied on the MDSC-A to identify significant changes and typically changes would be discussed in daily basis in stand up. The DON indicated that she relied on the MDSC-A, data collection and the MDSC-A to inform the interdisciplinary team of significant changes to discuss. | F 637 | | |

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| F 637 | Continued From page 8<br>A facility policy was requested for recognition and completion of resident SCSA MDS's, none were provided.<br><br>The Resident Assessment Instrument manual dated 10/17, included the definition of a significant change as a decline or improvement in a resident's status that:<br><br>1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";<br>2. Impacts more than one area of the resident's health status; and<br>3. Requires interdisciplinary review and/or revision of the care plan.<br><br>The manual further directed when the interdisciplinary team (IDT) determined that a significant change occurred, the nursing home should document the initial identification of the significant change in the clinical record. The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. The manual clarified that MDS assessments are not required for minor or temporary variations in resident status. | F 637 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent | F 689 | | 8/2/18 |

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| F 689 | Continued From page 9<br>accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 9 of 13 resident bathrooms (RB) (RB213, RB305, RB412, RB407, RB401, RB103, RB201, RB203 and RB206) tested for safe water temperatures. This had the potential to effect all 39 residents that currently resided in the facility.<br><br>Finding include:<br><br>During the environmental tour on 7/9/18, at 9:09 p.m. the maintenance supervisor (MS) checked the water temperatures with the facility Extech Easy View thermometer. The following water temperatures were observed:<br>- RB 213 was 123.3 degrees Fahrenheit (F)<br>- RB 305 was 125.5 degrees (F)<br>- RB 412 was 128.8 degrees (F)<br>- RB 407 was 128.4 degrees (F)<br>- RB 401 was 120.9 degrees (F)<br>- RB 103 was 123.2 degrees (F)<br>- RB 201 was 131.0 degrees (F)<br>- RB 203 was 125.2 degrees (F)<br>- RB 206 was 122.4 degrees (F)<br><br>On 7/9/18 at 9:09 p.m. MS confirmed the water temperatures were above acceptable temperature of 115 degrees (F) and indicated he would felt the temperatures would be running high due to the outside temperature running 90 degrees (F) and the facility's 1970's model boiler. The MS indicated the facility had been considering a new system and was hoping to get it fixed this year. The MS indicated that he only | F 689 | The gage on the water heating system was immediately reduced on 7-9-18 when the problem was identified.Education of nursing staff was provided immediately upon the identification of the deficient practice to those on duty. Staff will monitor and log temperatures on each shift daily to ensure that temperatures are with in the range of 90-105 degrees Fahrenheit. A log will be kept for auditing purposes. Further staff re-education was completed on 7-31-18. Halstad Living Center will be installing two new water heaters and one new electronically controlled mixing valve on August 2, 2018 to ensure that it will eliminate the fluctuation of the water temperatures in the evening hours. To ensure this deficient practice no longer occurs; water temperatures will be tested twice monthly on the day, evening and night shifts and recorded on the water temperature log sheets. In the event water temperatures are above 115 degrees Fahrenheit, Maintenance staff will be called to immediately correct the problem. Water temperature logs will be monitor by the QA/QAPI Committees, quarterly and monthly respectively. | |

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| F 689 | Continued From page 10<br>tested water temperatures during the day hours only, had not received any complaints of hot water and was not aware of the water temperatures running this high. The MS indicated he would like to see the water temperatures run about 112 degrees (F) and stated "I cannot hold it at 112 degrees (F)."<br><br>Review of the facility monthly water temperature audits, revealed the audits were completed for the last 3 months during day hours, with the last audit completed on 6/6/18. Further review of the logs revealed water temperatures were not checked randomly on other shifts.<br><br>On 7/12/18 at 11:21 a.m. the Administrator confirmed the facility did not know they had a problem with hot water temperatures on the evening shift and verified BR201, BR203, BR412 were used by cognitively impaired resident who could use the BR's independently. The Administrator verified the MS turned down the water temperature and staff were all educated on the hot water temperatures after the high water temperatures were identified on 7/9/18 and indicated the facility would be getting a new boiler system in the near future.<br><br>Review of facility policy titled, Water Temperatures dated 7/18, indicated water heaters that service resident rooms, bathrooms, common areas and tub/shower area shall be set to temperatures of no more than 115 degrees (F) or maximum allowable temperature per state regulation. | F 689 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2) | F 812 | | 7/27/18 |

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| F 812 | Continued From page 11<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure clean and sanitary kitchen equipment, refrigerated food items were disposed of after expiration dates and frozen foods were properly stored and dated for 1 of 1 walk in cooler/freezer. This had the potential to affect 38 of the 39 residents that received food from the kitchen. In addition the facility failed to maintain the water and ice machine to prevent potential contamination for all 38 out of 39 residents who currently resided in the facility.<br><br>Findings include:<br><br>On 7/9/18 at 6:22 p.m. during an initial tour of the facility with cook (C)-A the following concerns were identified in the walk in freezer:<br>- a box of french fries which contained six 5 | F 812 | F812<br>Upon identification of the deficient conditions of the water/ice machine and microwave, both the water/ice machine and the microwave were cleaned immediately by kitchen staff.<br>All foods that were found on the floor of the freezer were removed and discarded immediately. Any foods that were not labeled and dated appropriately were discarded immediately. All staff were re-trained in storage of foods at least 6" off of floors and in correct labeling and dating of any foods outside of original containers by 7-26-18. CDM will inspect storage areas daily to ensure that foods are stored off the floor and that all foods are labeled and dated appropriately. | |

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| F 812 | Continued From page 12<br>pound packages of french fries was setting in the middle of the floor of the walk in freezer floor<br>- two 5 pound bags of ice in a plastic grocery bag was setting on the floor under the shelf to the left of the walk in freezer<br>- a box of apple pie filling was setting on the floor on the floor in the back left corner of the walk in freezer.<br>- a serving tray with eleven dessert cups filled with ice cream uncovered and undated setting in the middle of the walk in freezer was setting on top of a cardboard box.<br>C-A confirmed the above findings and indicated food items should not to be on the floor and should be properly covered and dated.<br><br>On 7/10/18 at 10:39 a.m. during a tour of the kitchen with the dietary manager (DM) the following concerns were identified:<br>- a white microwave setting on the counter out in the main dining room area had yellow grease splatters covering all surfaces of the inside of the microwave oven.<br>- the water and ice machine located in the main dining room of the facility had encrusted hard water lime scale build up with flakes under the ice and water dispenser. The tray was also noted to have light water lime scale build up and the metal grate was rusted.<br>- one half gallon of milk, with expiration date of 7/1/18.<br><br>The DM confirmed the above findings and indicated the microwave should be cleaned daily. The DM indicated the inside of the water and ice machine was cleaned monthly and indicated they use a de-limer to clean the outside of the ice and water dispenser and indicated this was to be done weekly or when needed. The DM also | F 812 | Policy & procedures addressing sanitation and food safety will be reviewed to assure adequate monitoring of equipment cleanliness and food safety practices. Dietary staff will re-trained on all appropriate sanitation and food safety policies by July 27, 2018.<br><br>The CDM will complete audits of the freezer, refrigerator, dry storage areas, microwave and ice machine randomly twice a week for a month, correcting any areas that are not satisfactorily met and re-training staff on the spot as to steps to take to ensure sanitation and food safety.<br><br>The CDM will report results of the above audit and corrective actions taken at the next QA and QAAPI meetings. If results of the audit show continued problems over the month of review, the audit will be continued at 2 times a week for another months with reporting to the QA committee by the CDM for up to 6 months.<br><br>A Food Safety & Sanitation Checklist will become part of Food & Nutrition QA policy and program with the CDM completing one on a monthly basis and the Consultant Dietitian completing one on a quarterly basis. Results of each inspection will be reviewed with Dietary staff and corrections made as necessary. | |

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| | 245569 | A. BUILDING _____ B. WING _____ | 07/12/2018 |

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

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| F 812 | Continued From page 13 | F 812 | | |

indicated food should not be stored on the floor due to it being dirty and the items could become contaminated. The DM confirmed the facility should not have expired products in the fridge and should be properly stored and labeled.

Reviewed of facility policy titled, Food and Nutrition undated, indicated Halstad Living Center will provide safe and sanitary storage, handling, and consumption of all foods including those brought to the resident by family and other visitors. The policy listed various definitions of terms related to sanitary conditions and the prevention of foodborne illness which included cross contamination, food contamination and identified a highly susceptible population as persons who are more likely than the general population to experience foodborne illness because of their susceptibility to becoming ill if they ingest microorganisms or toxins. Increased susceptibility may be associated with immune-compromised health status, chronic disease and advanced age. The Food and Drug Adminstration's Food Code includes nursing facilities in its definition of a "highly susceptible population."

Review of facility policy titled, Cleaning Schedule revised on 4/2005, indicated the following items will be cleaned daily: microwaves and ice machine (exterior). Under weekly: ice machines (preventive maintenance), refrigerators and freezers.

Review of facility policy titled, Ice Machine dated 6/18, indicated under: monthly- preventive maintenance cleaning allows cleaning the ice machine without removing all of the ice from the bin. It removes mineral deposits from areas or

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| F 812 | Continued From page 14<br>surfaces that are in direct contact with water during the freeze cycle. | F 812 | | |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshal Division. At the time of this survey Halstad Living Center 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>"If participating in the E-POC process, a paper copy of the plan of correction is not required."<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:<br><br>Health Care Fire Inspections | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/26/2018 |

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<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101<br><br>Or by e-mail to:<br>Marian.Whitney@state.mn.us<br>and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency<br><br>Halstad Living Center was built in 1977 as a 1-story building without a basement and was determined to be Type II (000) construction. In 1990 a 1-story addition to the dining room was constructed to the east of the original building and was determined to be Type II (111) construction. In 1998 a dining addition was constructed to the west of 200 wing and an addition to the south to connect to the apartment building. These additions are 1 story without a basement and were determined to be of a Type II (111) construction. The building is divided into 5 smoke zones with 1/2 hour fire rated barriers.<br><br>The entire building is sprinkler protected in | K 000 | | |

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| K 000 | Continued From page 2<br>accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code". Hazardous areas have automatic fire detectors that are on the fire alarm system.<br><br>Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building.<br><br>The facility has a capacity of 44 beds and had a census of 39 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 131 SS=E | Multiple Occupancies<br>CFR(s): NFPA 101<br><br>Multiple Occupancies - Sections of Health Care Facilities<br>Sections of health care facilities classified as other occupancies meet all of the following:<br><br>o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access.<br>o They are separated from areas of health care occupancies by<br>construction having a minimum two hour fire resistance rating in<br>accordance with Chapter 8.<br>o The entire building is protected throughout by an approved, supervised<br>automatic sprinkler system in accordance with | K 131 | | 8/1/18 |

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| K 131 | Continued From page 3<br>Section 9.7.<br><br>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served.<br>19.1.3.3, 42 CFR 482.41, 42 CFR 485.623<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and affecting an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>On the facility tour between 11:00 am to 2:00 pm on 07/11/2018 observations revealed the 2 hour fire barrier separating the residential wings from the service area of the bldg did not have listed fire stopping above the cross corridor doors at the roof line.<br><br>This deficient condition was confirmed by the Maintenance Director. | K 131 | To correct K tag 131, Halstad Living Center will remove fifteen feet of fiberglass insulation and the remaining gap will be filled with 3M Fire Barrier Rated Foam FIP. This will be completed by 8-1-18. | |
| K 293<br>SS=D | Exit Signage<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1 | K 293 | | 8/2/18 |

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| K 293 | Continued From page 4<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview the facility failed to properly identify an exit door in the path of egress as required in The Life Safety Code NFPA 101 2012 edition section 7.10.8.3. This deficient condition could affect the exiting of an undetermined amount of residents, staff and visitors.<br><br>Findings include:<br><br>On the facility tour between 11:00 am to 2:00 pm on 07/11/2018 observations revealed an exit not identified with lighted signage in the Heritage link.<br><br>This deficient condition was confirmed by the Maintenance Director. | K 293 | An exit sign and combo exit sign will be installed in the deficient area on or before August 2, 2018. | |
| K 321<br>SS=D | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>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.<br>Describe the floor and zone locations of | K 321 | | 7/23/18 |

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| K 321 | Continued From page 5<br>hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to maintain one combustible storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>On the facility tour between 11:00 am to 2:00 pm on 07/11/2018 observations revealed the activities storage room, over 50 sq ft with combustibles, did not have a self closing door.<br><br>This deficient condition was confirmed by the Maintenance Director. | K 321 | Door closures were installed to the deficient area on July 23, 2018. | |
| K 341 SS=E | Fire Alarm System - Installation<br>CFR(s): NFPA 101 | K 341 | | 8/6/18 |

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| K 341 | Continued From page 6<br>Fire Alarm System - Installation<br>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, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 12 of the 50 residents and an undetermined amount of patients, staff and visitors.<br><br>Findings include:<br><br>On the facility tour between 11:00 am to 2:00 on 07/11/2018 observations revealed the corridor in the 200 wing was not properly protected by smoke detectors. The distance between detectors was 39 feet. | K 341 | Installation of the additional smoke detector has been scheduled with Simplex on August 6, 2018. | |

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| K 341 | Continued From page 7<br>This deficient condition was confirmed by the Maintenance Director. | K 341 | | |
| K 353 SS=E | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>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, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview the facility failed to ensure the proper sprinkler coverage was maintained according to NFPA 101 Life Safety Code (12) section 9.7.6 and NFPA 13, The Installation of Sprinkler Systems, section 16.1.6.1. This deficient practice could allow for the spread of fire affecting 16 of the 50 residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>On the facility tour between 11:00 am to 2:00 pm | K 353 | The deficient shelves in store room 418 have been removed and replaced with wire shelving. In store room 417, all items have been removed from the top shelves. There is 24 inches of space between the shelves and the sprinkler heads. | 7/23/18 |

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| K 353 | Continued From page 8<br>on 07/11/2018 observations revealed the following:<br>1. The stored items in the activities storage room was within 18 inches of the sprinkler deflector.<br>2. The stored items in storage rooms 418 & 417 were stacked to the ceiling.<br><br>This deficient condition was confirmed by the Maintenance Director. | K 353 | | |
| K 372 SS=E | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>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.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to maintain one smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 17 of the 50 residents and an undetermined amount of staff and visitors.<br><br>Findings include: | K 372 | The identified penetrations have been plugged with 4 hour 3M putty. | 7/23/18 |

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| K 372 | Continued From page 9<br><br>On the facility tour between 11:00 am to 2:00 pm on 07/11/2018 observations revealed two, 1 1/2 inch diameter penetrations in the smoke barrier above the cross corridor doors in the 300 wing.<br><br>This deficient condition was confirmed by the Maintenance Director. | K 372 | | |
| K 920 SS=E | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the | K 920 | Room 416 is free from all power strips. | 7/24/18 |

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| | 245569 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/11/2018** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 920 | Continued From page 10<br>facility failed to ensure multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2..4.2.1 and the use of power strips comply with 10.2.3.6. This deficient practice could affect and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>On the facility tour between 11:00 am to 2:00 pm on 07/11/2018 observations revealed, in resident room 416, 3 power strips connected together.<br><br>This deficient condition was confirmed by the Maintenance Director. | K 920 | All rooms have been checked with no power strips remaining. Completed 7-24-18. | |
| K 923 SS=E | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be | K 923 | | 7/23/18 |

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| K 923 | Continued From page 11<br>stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to store oxygen tanks in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 11.6.2.3 item 11. This deficient practice could accelerate the spread of fire. This condition could affect 17 of 50 residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>On the facilities tour between 11:00 am to 2:00 pm on 07/11/2018 observations revealed combustibles were being stored within 5 feet of oxygen in the oxygen storage room in the 400 wing.<br><br>This deficient condition was confirmed by the Maintenance Director. | K 923 | All combustibles were removed from the 400 wing storage room. The only item remaining is the oxygen tank. | |

Electronically delivered
July 23, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5569030

Dear Ms. Nelson:

The above facility was surveyed on July 9, 2018 through July 12, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson, Unit Supervisor at (218) 332-5140 or gail.anderson@state.mn.us.

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

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

Please feel free to call me with any questions.

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00764 | A. BUILDING: _____ B. WING _____ | 07/12/2018 |

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

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>On 7/9/18 to 7/12/18, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.<br><br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |

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| 2 000 | Continued From page 2<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 545 | MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency<br><br>Subp. 3. Frequency. Comprehensive resident assessments must be conducted:<br>A. within 14 days after the date of admission;<br>B. within 14 days after a significant change in the resident's physical or mental condition; and<br>C. at least once every 12 months.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 2 (R22) residents reviewed for a decline activities of daily living (ADL's).<br><br>Findings include:<br><br>R22's quarterly Minimum Data Set (MDS) dated | 2 545 | Corrected.<br>All residents will be reviewed for a significant change in IDT meetings Monday-Friday and with each quarterly and annual MDS assessment. A record of this review will be kept for auditing purposes. The members of the IDT team will be provided education on significant change identification on 8-2-18. | 8/2/18 |

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| 2 545 | Continued From page 3<br><br>3/6/18, identified R22 had severe cognitive impairment and had diagnoses which included Alzheimer's, dementia and Parkinson's. The MDS identified R22 required extensive assistance of two staff for ADL's, bed mobility, transfers, dressing, toileting, personal hygiene and extensive assistance of one staff for eating. The MDS identified R22 required total assistance of one staff for locomotion on and off the unit, did not ambulate and required total assistance of two staff for bathing. The MDS revealed R22's weight at the time of the MDS was 149 pounds (lbs.) The MDS also identified R22 was frequently incontinent of bowel and bladder and was not on a toileting program.<br><br>R28's quarterly MDS dated 5/29/18, identified R22 had severe cognitive impairment and had diagnoses which included Alzheimer's, dementia and Parkinson's. The MDS identified R22 was totally dependent of two staff for with ADL's for bed mobility, transfers, dressing, toileting, personal hygiene, bathing and totally dependent of one staff for eating, locomotion on and off the unit and did not ambulate. The MDS revealed R22's weight at the time of the MDS was 139 lbs, a 10 lb weight loss since R28's last MDS. The MDS also identified R22 was always incontinent of bowel and bladder and was not on a toileting program.<br><br>Review of R22's quarterly MDS assessments indicated R22 had a 10 lb weight loss, required increase need for staff assistance in bed mobility, transfers, dressing, toileting, personal hygiene and eating. The assessment further indicated R22 had a decline in bowel and bladder incontinence from frequently to always incontinent. | 2 545 | | |

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| 2 545 | Continued From page 4<br><br>On 7/12/18 at 10:24 a.m. trained medication aid (TMA)-A she stated R22 required total assistance from staff for all of his ADL's and indicated R22 had not really changed except for he used to feed himself on the evening shift at times.<br><br>On 7/12/18 at 10:35 a.m. licensed practical nurse (LPN)-A confirmed R22 required total assistance from staff for all of his ADL's, used a full mechanical lift for transfers and used to require extensive assistance of two staff with cares.<br><br>On 7/12/18 sat 10:52 a.m. the facility MDS coordinator (MDSC)-A confirmed she had completed both of R22's aforementioned MDS's. The MDSC-A indicated R22 would fluctuate from extensive assistance to total assistance of two staff. The MDSC-A indicated after review R22 would have had a significant change in urinary incontinence and ADL's and indicated a significant change MDS should have been done. The MDSC-A indicated that she had made a mistake and R22 had two or more care area changes in a group and missed it. The MDSC-A indicated she followed the MDS guide/bible meaning resident assessment instrument (RAI manual).<br><br>On 7/12/18 at 11:14 a.m. director of nursing (DON) indicated that she relied on the MDSC-A to identify significant changes and typically changes would be discussed in daily basis in stand up. The DON indicated that she relied on the MDSC-A, data collection and the MDSC-A to inform the interdisciplinary team of significant changes to discuss.<br><br>A facility policy was requested for recognition and completion of resident SCSA MDS's, none were provided. | 2 545 | | |

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| 2 545 | Continued From page 5<br><br>The Resident Assessment Instrument manual dated 10/17, included the definition of a significant change as a decline or improvement in a resident's status that:<br><br>1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";<br>2. Impacts more than one area of the resident's health status; and<br>3. Requires interdisciplinary review and/or revision of the care plan.<br><br>The manual further directed when the interdisciplinary team (IDT) determined that a significant change occurred, the nursing home should document the initial identification of the significant change in the clinical record. The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. The manual clarified that MDS assessments are not required for minor or temporary variations in resident status.<br><br>SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) and/or designee could review the Resident Assessment Instrument (RAI) Manual with responsible facility staff, in regards to how to complete a Significant Change of Status Assessment). The DON could develop a monitoring system to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 2 545 | | |

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| 21100 | Continued From page 6 | 21100 | | |
| 21100 | MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food<br><br>Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure clean and sanitary kitchen equipment, refrigerated food items were disposed of after expiration dates and frozen foods were properly stored and dated for 1 of 1 walk in cooler/freezer. This had the potential to affect 38 of the 39 residents that received food from the kitchen. In addition the facility failed to maintain the water and ice machine to prevent potential contamination for all 38 out of 39 residents who currently resided in the facility.<br><br>Findings include:<br><br>On 7/9/18 at 6:22 p.m. during an initial tour of the facility with cook (C)-A the following concerns were identified in the walk in freezer:<br>- a box of french fries which contained six 5 pound packages of french fries was setting in the middle of the floor of the walk in freezer floor<br>- two 5 pound bags of ice in a plastic grocery bag was setting on the floor under the shelf to the left of the walk in freezer<br>- a box of apple pie filling was setting on the floor on the floor in the back left corner of the walk in freezer.<br>- a serving tray with eleven dessert cups filled with ice cream uncovered and undated setting in | 21100 | Corrected.<br>All foods that were found on the floor of the freezer were removed and discarded immediately. Any foods that were not labeled and dated appropriately were discarded immediately. All staff were re-trained in storage of foods at least 6" off of floors and in correct labeling and dating of any foods outside of original containers. CDM will inspect storage areas daily to ensure that foods are stored off the floor and that all foods are labeled and dated appropriately. | 7/27/18 |

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| 21100 | Continued From page 7<br>the middle of the walk in freezer was setting on top of a cardboard box.<br>C-A confirmed the above findings and indicated food items should not to be on the floor and should be properly covered and dated.<br><br>On 7/10/18 at 10:39 a.m. during a tour of the kitchen with the dietary manager (DM) the following concerns were identified:<br>- a white microwave setting on the counter out in the main dining room area had yellow grease splatters covering all surfaces of the inside of the microwave oven.<br>- the water and ice machine located in the main dining room of the facility had encrusted hard water lime scale build up with flakes under the ice and water dispenser. The tray was also noted to have light water lime scale build up and the metal grate was rusted.<br>- one half gallon of milk, with expiration date of 7/1/18.<br><br>The DM confirmed the above findings and indicated the microwave should be cleaned daily. The DM indicated the inside of the water and ice machine was cleaned monthly and indicated they use a de-limer to clean the outside of the ice and water dispenser and indicated this was to be done weekly or when needed. The DM also indicated food should not be stored on the floor due to it being dirty and the items could become contaminated. The DM confirmed the facility should not have expired products in the fridge and should be properly stored and labeled.<br><br>Reviewed of facility policy titled, Food and Nutrition undated, indicated Halstad Living Center will provide safe and sanitary storage, handling, and consumption of all foods including those brought to the resident by family and other | 21100 | | |

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

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| 21100 | Continued From page 8<br>visitors. The policy listed various definitions of terms related to sanitary conditions and the prevention of foodborne illness which included cross contamination, food contamination and identified a highly susceptible population as persons who are more likely than the general population to experience foodborne illness because of their susceptibility to becoming ill if they ingest microorganisms or toxins. Increased susceptibility may be associated with immune-compromised health status, chronic disease and advanced age. The Food and Drug Adminstration's Food Code includes nursing facilities in its definition of a "highly susceptible population."<br><br>Review of facility policy titled, Cleaning Schedule revised on 4/2005, indicated the following items will be cleaned daily: microwaves and ice machine (exterior). Under weekly: ice machines (preventive maintenance), refrigerators and freezers.<br><br>Review of facility policy titled, Ice Machine dated 6/18, indicated under: monthly- preventive maintenance cleaning allows cleaning the ice machine without removing all of the ice from the bin. It removes mineral deposits from areas or surfaces that are in direct contact with water during the freeze cycle.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of dietary services or designee could development and implement policies and procedures to food preparation equipment were cleaned and maintained regularly and ensure store refrigerated food items were properly labeled, dated to ensure they were used or discard by the expiration date. The director of | 21100 | | |

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| 21100 | Continued From page 9<br>dietary services or designee could educate staff on those policies, and then monitor the appropriate staff for adherence to the policies and procedures.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days | 21100 | | |
| 21710 | MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance<br><br>Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure an environment that was free of accident hazards, related to hot water temperatures in 13 of 13 resident bathrooms (RB) (RB213, RB305, RB412, RB407, RB401, RB103, RB201, RB203, RB206, RB311, RB404, RB403 and RB402) tested for safe water temperatures. This had the potential to effect all 39 residents that currently resided in the facility.<br><br>Finding include:<br><br>During the environmental tour on 7/9/18 at 9:09 p.m. the maintenance supervisor (MS) checked the water temperatures with the facility Extech Easy View thermometer. The following water temperatures were observed:<br>- RB 213 was 123.3 degrees Fahrenheit (F)<br>- RB 305 was 125.5 degrees (F) | 21710 | Corrected.<br>The gage on the water heating system was immediately reduced on 7-9-18 when the problem was identified. Education of nursing staff was provided immediately upon the identification of the deficient practice to those on duty. Staff will monitor and log temperatures on each shift daily to ensure that temperatures are with in the range of 90-105 degrees Fahrenheit. A log will be kept for auditing purposes. Further staff re-education was completed on 7-31-18. Halstad Living Center will be installing two new water heaters and one new electronically controlled mixing valve on August 2, 2018 to ensure that it will eliminate the fluctuation of the water temperatures in the evening hours. | 8/2/18 |

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| 21710 | Continued From page 10<br>- RB 412 was 128.8 degrees (F)<br>- RB 407 was 128.4 degrees (F)<br>- RB 401 was 120.9 degrees (F)<br>- RB 103 was 123.2 degrees (F)<br>- RB 201 was 131.0 degrees (F)<br>- RB 203 was 125.2 degrees (F)<br>- RB 206 was 122.4 degrees (F)<br>- RB 311 was 118.8 degrees (F)<br>- RB 404 was 115.2 degrees (F)<br>- RB 403 was 117.3 degrees (F)<br>- RB 402 was 119.1 degrees (F)<br><br>On 7/9/18 at 9:09 p.m. MS confirmed the water temperatures were above acceptable temperature of 115 degrees (F) and indicated he would imagine the temperatures would be running high due to the outside temperature running 90 degrees (F) and 1970's boiler. The MS indicated the facility has quite's out to get a new system and was hoping to get it fixed this year. The MS indicated that he only tests the water temperatures during the day hours only, had not received any complaints of hot water and was not aware of the water temperatures running this high. The MS indicated he would like to see the water temperatures run about 112 degrees (F) and stated "I cannot hold it at 112 degrees (F)."<br><br>Review of the facility monthly water temperature audits, revealed the audits were completed for the last 3 months during day hours, with the last audit completed on 6/6/18. Further review of the lags revealed water temperatures were not checked randomly on other shifts.<br><br>On 7/12/18 at 11:21 a.m. the Administrator confirmed the facility did not know they had a problem with hot water temperatures on the evening shift and verified BR201, BR203, BR412, | 21710 | | |

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| 21710 | Continued From page 11<br><br>BR 311 were used by cognitively impaired resident who could use the BR's independently. The Administrator verified the MS turned down the water temperature and staff were all educated on the hot water temperatures after the high water temperatures were identified on 7/9/18 and indicated the facility would be getting a new boiler system in the near future.<br><br>Review of facility policy titled, Water Temperatures dated 7/18, indicated water heaters that service resident rooms, bathrooms, common areas and tub/shower area shall be set to temperatures of no more than 115 degrees (F) or maximum allowable temperature per state regulation.<br><br>SUGGESTED METHOD FOR CORRECTION: The Environmental Director, Director of Nursing and/or designee could monitor and develop a system to review water temperatures at the resident level on a weekly basis to ensure they are between 105 and 115 degrees Fahrenheit.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21710 | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.<br><br>This MN Requirement is not met as evidenced by: | 21805 | | 7/30/18 |

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| 21805 | Continued From page 12<br><br>Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 1 resident (R18) who was reviewed for tracheal care.<br><br>Findings include:<br><br>R18's quarterly Minimum Data Set (MDS), dated 5/15/18, identified R18 had diagnoses which included dementia, Parkinson's, dysphasia (difficulty swallowing) and encounter for attention to tracheostomy(artificial opening into the trachea through the neck.) R18's MDS identified R18 had both short term and long term memory problems and had severely impaired cognitive skills for daily decision making. Further, The MDS indicated R18 required total assistance from staff with activities of daily living (ADL's) and received tracheostomy care.<br><br>R18's care plan revised on 5/25/18, identified R18 had a potential for ineffective airway clearance related to tracheal secretions, dysphagia and coronary obstructive pulmonary disease (COPD). The care plan listed various interventions which included nursing to monitor respiratory status, sputum, oxygen saturation levels every shift and as needed. R18's also had an ADL self care deficit related limited mobility, history of stroke, Parkinson's and cognitive impairment. The care plan listed various interventions which included totally dependent on two staff for personal hygiene and one staff for oral care.<br><br>During observations on 7/11/18 at 7:13 a.m. R18 was seated in his wheelchair out in the commons area next to the nurses station. R18 had a multi-colored clothing protector draped across his chest area and tied behind his neck. R18 had a tracheostomy with copious amounts of thick, | 21805 | Corrected.<br>All residents with tracheostomies will be assessed for respiratory secretions and will be placed on a scheduled for change clothing protector every hour and as needed.<br>All nursing staff were educated on providing dignified care to residents with tracheostomies who have secretions on 7-26-18, 7-27-18 and 7-30-18. | |

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| 21805 | Continued From page 13 | 21805 | | |

yellow sputum hanging approximately three inches from his tracheostomy site onto his clothing protector. There was several other residents seated in the commons area next to R18 and staff members walking by the commons area, and two nurses passing medications in the commons area.
-at 7:24 a.m. R18 remained seated in his wheelchair out in the commons area next to the nurses station with other residents seated in the area. Copious amounts of thick, yellow sputum continued to be present hanging approximately three inches from his tracheostomy site onto his clothing protector.
-at 7:44 a.m. R18 remained seated in his wheelchair with several other residents in the commons area next to the nurses station with copious amounts of thick, yellow sputum hanging approximately three inches from his tracheostomy site onto his clothing protector.
-at 8:03 a.m. trained medication aid (TMA)-A and nursing assistant (NA)-A wheeled R18 back to his room, TMA-A removed the soiled multi-colored clothing protector from R18's chest area with copious amounts of thick, yellow sputum and placed a clean multi- colored clothing protector across R18's chest area and tied it behind his neck. TMA-A proceeded to shave R18's face while NA-A walked into the bathroom, gloved both hands and proceeded to check R18's brief for incontinence.
-at 8:07 a.m. TMA-A wheeled R18 back out to the commons area by the nurses station.

During observations on 7/12/18 at 8:29 a.m. R18 was seated in his wheelchair out in the commons area next to the nurses station. R18 had a multi-colored clothing protector draped across his chest area and tied behind his neck. R18 had copious amounts of thick, yellow sputum on his

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| 21805 | Continued From page 14<br>clothing protector. There was several other residents seated in the commons area near and next to R18, and several staff members walking by the commons area, two nurses passing medications in the commons area.<br>-at 8:33 a.m. TMA-A approached R18 while he was seated in his wheelchair in the commons area with the other residents and wheeled him back to his room. TMA-A gloved, removed the soiled clothing protector from R18's chest area, place a clean multi- colored clothing protector across his chest area and tied it behind his neck. TMA-A proceeded to wheel R18 back out to the commons area by the nurses station.<br><br>On 7/12/18 at 8:34 a.m. TMA-A confirmed R18 had a lot of phlegm on his clothing and indicated it happens quite a bit. TMA-A indicated when staff noticed the phlegm, they would bring him back to his room and change his clothing protector.<br><br>On 7/11/18 at 1:25 p.m. licensed practical nurse (LPN)-B confirmed R18 needed total assistance from staff with ADL's and indicated she expected staff to change R18's clothing protector when soiled. LPN-B indicated she felt other residents and visitors might be uncomfortable seeing the large amount of sputum/phlegm on R18's clothing protector. LPN-B indicated she felt R18 would be embarrassed if he knew he had sputum/phlegm on his clothing protector.<br><br>On 7/12/18 AT 8:39 a.m. LPN-A confirmed R18 needed total assistance from staff with ADL's and always had lots of secretions from his tracheal site. LPN-A indicated staff should be monitoring R18 more and indicated staff were to change R18's clothing protector when soiled. LPN-A indicated she had been thinking about this and indicated dignity was the big thing with R18's | 21805 | | |

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| 21805 | Continued From page 15<br>secretions and staff need to be aware of it.<br><br>On 7/12/18 at 8:48 a.m. director of nursing (DON) confirmed R18 needed total assistance from staff with ADL's and indicated staff clean R18's sputum on his clothing protector when they see it.<br><br>Review of facility policy titled, Dignity revised on 2/2017, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.<br><br>SUGGESTED METHOD OF CORRECTION: The director of dietary services or designee could development and implement policies and procedures dignified care for all residents. The director of dietary services or designee could educate staff on those policies, and then monitor the appropriate staff for adherence to the policies and procedures.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days | 21805 | | |