DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 4, 2023

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

RE: CCN: 245512
Cycle Start Date: August 17, 2023

Dear Administrator:

On September 29, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 4, 2023

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

Re: Reinspection Results
Event ID: OXL312

Dear Administrator:

On September 29, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 17, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 7, 2023

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

RE: CCN: 245512
Cycle Start Date: August 17, 2023

Dear Administrator:

On August 17, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 17, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 17, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	08/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/14/23 through 8/17/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/14/23 through 8/17/23, a standard recertification 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, Requirements for Long Term Care Facilities. Your facility was not in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		9/20/23

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

Electronically Signed | 09/18/2023

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

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F 641	Continued From page 1 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the hospice status on the Minimum Data Set (MDS) for 1 of 1 residents (R28) reviewed hospice services. Findings include: R28's quarterly MDS dated 6/27/23, identified R28 had diagnoses that included chronic kidney disease, hypertensive heart disease, and legal blindness. The MDS failed to identify R28 received hospice care in section O- Special Treatments and Programs. R28's care plan dated 7/24/23, identified R28 received hospice services due to end stage heart failure. During an interview on 8/16/23 at 3:28 p.m., registered nurse (RN)-A stated she missed entering R28's hospice services and had been on hospice services for awhile. During an interview on 8/16/23 at 4:03 p.m. the director of nursing (DON) stated R28 was on hospice for some time. The DON stated MDS assessment accuracy was important because it drove payment, staffing needs and was basis for everything long term care related. The facility policy Minimum Data Set revised 6/14/21, identified the MDS was a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual	F 641	The facility modified the MDS identified with an error to correct section O so MDS indicated resident was on hospice care. MDS for all current residents on hospice care were reviewed. No other errors found. Will audit MDS for all residents on hospice care monthly for accurate hospice identification. Audits will continue until there have been 3 consecutive months of 100% compliance or a minimum of 6 months. Audit results will be reported to QAPI for review. Director of Nursing responsible for ensuring audits are completed and reported to QAPI committee.	

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F 641	Continued From page 2 nursing home resident to provide the facility with the information necessary to develop a care plan and to provide appropriate care and services for each resident and to modify the care lan and care/services based on resident status. Staff were directed to refer to the Resident Assessment Instrument (RAI) manual for further instructions, definitions and guidance.	F 641		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow care planned interventions to prevent falls for 1 of 1 residents (R27) reviewed for falls. Findings include: R27's significant change Minimum Data Set (MDS) dated 7/4/23, identified R27 had severe cognitive impairment and required extensive assistance to total dependence for all care areas. Diagnoses included dementia and a history of falling. R27's falls Care Area Assessment (CAA) dated 7/17/23, identified R27 was a high fall risk and balance concerns. R27's contributing factors	F 689	Direct care staff (RN, LPN, TMA, and CNA) were educated at time of survey and at staff meetings on 9/6 & 9/7/23 on importance of following individualized resident plan of care, use the tools available (tape on wall & profile in closet) as reference to ensure each resident's bed is left at the proper height, and appropriate individualized fall prevention interventions. Audits will be completed weekly to verify beds are left at the correct height for resident room being audited and staff are aware of how to access the resident plan of care. Audits will continue until there have been 3 consecutive months of 100% compliance or a minimum of 6 months.	9/15/23

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F 689	Continued From page 3 included: advanced age, impulsiveness, forgetfulness, R27 did not think that he needed help, cancer, urinary catheter, multiple falls reported prior to admit to facility with compression fractures and since admit he had continued to have multiple falls, one with fracture to hip that was most recent this summer, and taking an antidepressant and a diuretic. This placed R27 at risk for more falls, minor or serious injury, and possible need for re-hospitalization. R27's care plan dated 6/12/23, included interventions of fall mat at bedside (keep bed at knee height) and also for the bed to be at knee height rather than to the floor due to cathether bag touching floor. During an observation on 8/15/23 at 12:44 p.m. R27 was lying in bed with the bed in the lowest position. On 8/17/23 at 7:57 a.m., R27 was observed lying in bed. R27's room was darkened but R27 was clearly visible from the hallway. R27's bed was in the lowest position with a mat on the floor next the bed. R27 was curled up on his left side, facing the hallway. On 8/17/23 at 8:23 a.m., nursing assistant (NA)-B entered R27's room and stated R27's bed should not be in the low position and pointed to a piece of tape that was taped to the wall near R27's headboard. NA-B then raised R27's bed so that it was equal in level to the tape. On 8/17/23 at 8:36 a.m., licensed practical nurse (LPN)-A entered R27's room to assist NA-B with cares. LPN-A stated R27's bed not being at the correct care planned height could increase R27's	F 689	IDT will complete weekly audits of all fall documentation for completeness and effectiveness of interventions. Will complete formal audits for 6 months after which time fall documentation will continue to be reviewed for completeness and effectiveness of interventions. Audit results will be reported to QAPI for review. Director of Nursing responsible for ensuring audits are completed and reported to QAPI committee.	

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F 689	Continued From page 4 risk for falls. During an interview on 8/17/23 at 10:30 a.m., the director of nursing (DON) stated R27's care plan was updated after his fall with major injury in June 2023. Saff placed tape near the headboards of all residents' beds for staff to have a quick reference at what height the bed should be to lessen confusion. As always, the staff should follow the care plan and leadership was trying to break staff going by memory or verbal report. Staff should always ask if they are not sure or use the care plan that is posted in every resident's closet. The facility policy Fall and Fall with Injury Risk Assessment, Prevention and Management for Hospital and Ambulatory Settings reviewed 5/3/23, identified the facility's guiding principle was that all residents were at risk for falls. Universal Fall Precautions/Low Risk Interventions always applied to every resident. The registered nurse would use the fall risk assessment and risk for injury screeening tools to individualize the resident's care plan to reduce the risk of falls and/or fall-related injuries. The tools would be used to the assist the RN in the selection of appropriate risk reduction interventions to implement.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		9/12/23

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F 695	Continued From page 5 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess respiratory status and determine efficacy of oxygen therapy for 1 of 1 residents (R27) reviewed for respiratory services. Findings include: R27's significant change Minimum Data Set (MDS) dated 7/4/23, identified R27 had a severe cognitive impairment. The MDS did not identify R27 exhibited shortness of breath nor that R27 used oxygen. Diagnoses included heart disease, hypertension and diabetes. R27's physician order dated 3/6/23, Oxygen 2L via nasal cannula (NC) as needed (PRN). Special instructions: per standing orders R27's care plan dated 6/12/23, identified R27 had acute shortness likely due to interstitial lung disease. R27 evidenced of shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring, or when he takes of oxygen), shortness of breath or trouble breathing when sitting at rest if not wearing oxygen, and shortness of breath or trouble breathing when lying flat. Staff were directed to ensure: - R27's head of bed was to be elevated in increase oxygenation. Encourage upright position with dyspnea (shortness of breath). Encourage rest, semi-recumbent in bed or chair. Mobility assistance to assist with shortness of breath. - Identify other diagnoses and activities that may exacerbate symptoms of shortness of breath and	F 695	Oxygen order for the identified resident was changed to read “oxygen 2L per NC as needed” with special instructions requiring staff to document BID O2 sat, if below 90% apply O2, and document in results if O2 was applied/removed or left on/off. RN, LPN, TMA were educated at time of survey and again at staff meetings on 9/6 & 9/7/23, on the importance of documenting oxygen use, correct verbiage for oxygen orders, and following residents individualized plan of care. CNA staff were educated at time of survey and again at staff meetings on 9/6 & 9/7/23, on the importance of oxygen use and following residents individualized plan of care. 8/17/23 Oxygen orders for any residents utilizing oxygen therapy were updated on EMAR requiring documentation of O2 sat and liter flow. As needed orders included addition of if O2 sat is below 90% to apply oxygen (unless provider had identified alternative threshold) and section to document if O2 was on or off and if continued, removed, or applied. Entry made on care plan to elevate the HOB for resident on oxygen. Audits will be completed monthly to verify oxygen orders are entered correctly, oxygen use is documented, and plan of	

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F 695	Continued From page 6 the interventions utilized to decrease symptoms of shortness of breath. R27 had a history of a heart attack. - Treatment orders for symptom management included oxygen at 2 liters (L) as needed (PRN). During an observation on 8/15/23 at 5:39 p.m., R27 was sitting in his wheelchair in the common area with oxygen on at 2L per nc. During on observation on 8/15/23 at 7:39 p.m., nursing assistant (NA)-A, after assisting with bedtime cares, placed R27's nc into R27's nares and turned on his concentrator to 2L. During an observation on 8/16/23 at 1:50 p.m., R27 was lying in bed with oxygen on at 2L per nc. During an interview on 8/16/23 at 2:08 p.m., NA-I stated R27 always wore his oxygen at 2L per nc. During an interview on 8/16/23 at 2:28 p.m., NA-J stated R27 did not wear his oxygen during his bath but did at all other times. During an interview on 8/16/23 at 3:01 p.m. licensed practical nurse (LPN)-B stated R27's oxygen order was a standing order. Staff could apply it when R27 asked for it or was short of breath. The administration of oxygen should be documented on the MAR and staff should obtain an oxygen saturation and a general condition which should be documented as well. Upon review of R27's MAR, LPN-B stated it was not documented that R27 was receiving oxygen. LPN-B confirmed she was the nurse responsible for R27's medication administration that day, but stated she was unaware R27 was receiving oxygen. LPN-B stated she did not apply his nc	F 695	care reflects oxygen use and any appropriate respiratory related interventions are included. Audits will continue until there have been 3 consecutive months of 100% compliance or a minimum of 6 months. Audit results will be reported to QAPI for review. Director of Nursing responsible for ensuring audits are completed and reported to QAPI committee.	

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F 695	Continued From page 7 and was unaware of who did. R27's Medication Administration Records identified the following: - June 2023 MAR identified R27 did not use oxygen. - July 2023 MAR identified R27 did not use oxygen. - August 2023 MAR identified R27 did not use oxygen between 8/1/12 and 8/17/23. The medical record from June 2023 through August 2023 lacked any assessment related to R27's respirtatorty status. During an interview on 8/16/23 at 3:17 p.m. registered nurse (RN)-A stated she was the charge nurse that day. Upon review of R27's physician's orders, stated R27's oxygen order was a standing order that should be updated by the physician. RN-A stated staff should always document administration of oxygen because it assisted staff and R27's physician to recognize a change of condition or worsening. During an interview on 8/16/23 at 3:37 p.m., the director of nursing (DON) stated staff were expected to document administration of oxygen as well as document resident condition to warrant the administration. The facility policy Oxygen Administration dated 3/2023, directed staff to review provider order for administration of oxygen and appropriate flow rate. Document use of oxygen and saturation monitoring per physician's order in the treatment	F 695		

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F 695	Continued From page 8 record.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		9/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	08/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper catheter care was provided to prevent infection for 1 of 3 residents (R27) reviewed for catheter. Findings include: R27's significant change Minimum Data Set	F 880	The bed of the resident identified was raised to proper height, so the catheter bag was no longer on the floor. All direct care staff (RN, LPN, TMA, and CNA) were educated at time of survey and again at staff meetings on 9/6 & 9/7/23, on catheter care including bag	

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F 880	Continued From page 10 (MDS) dated 7/4/23, identified R27 had severe cognitive impairment and utilized an indwelling urinary catheter. Diagnoses included dementia, diabetes and cancer. R27's care plan dated 6/12/23, identified R27 used an indwelling urinary catheter due to obstructive uropathy (a condition of excess urine accumulation in kidney(s) that causes swelling of kidneys). Staff were directed to empty R27's catheter bag each shift and as needed. Record output total and appearance. During an observation on 8/17/23 at 7:57 a.m. R27 was lying in bed with his uncovered catheter bag lying on the floor. At 8:23 a.m., nursing assistant (NA)-B entered R27's room and stated R27's catheter bag should not be lying on the floor without a protective barrier such a bag cover. - At 8:13 a.m., NA-A applied a gown and gloves and gathered supplies to perform catheter care for R27. - At 8:27 a.m., NA-B picked up R32's catheter bag, placed paper towels on the floor and attempted to open the drainage port. However, NA-B stated she was unable to open the port and stated she needed the nurses' assistance. - At 8:30 a.m., NA-B opened an alcohol swab but laid it on it R32's bed. - At 8:32 a.m. licensed practical nurse (LPN)-A entered R32's room to assist NA-B. LPN-B applied a gown and gloves, then demonstrated the opening of the drainage port to NA-A. However, neither LPN-A nor NA-A cleaned the drainage port with the alcohol swab prior to opening the port. - At 8:35 a.m., once the catheter bag was empty, NA-B closed the drainage port and cleaned the	F 880	placement and technique for emptying (to reduce risk of infection and promote proper drainage), proper hand hygiene (including process and appropriate times for glove use and hand hygiene), and CDC recommendations related to enhance barrier precautions. All residents were reviewed to identify residents with catheters, tube feedings, draining wounds, and MDRO infections. New PPE door caddies were ordered and installed on bathroom doors of the residents identified on review. The new caddies are more visible for staff than previous PPE storage units. Direct care staff (RN, LPN, TMA, and CNA) were educated on use of new PPE door caddies including how to identify if resident is in a double occupancy room. Audits will be completed monthly to verify staff are following enhanced barrier precaution recommendations. Infections are already monitored and reported to QAPI meetings monthly. Audits will continue until there have been 3 consecutive months of 100% compliance or a minimum of 6 months. Audit results will be reported to QAPI for review. Director of Nursing responsible for ensuring audits are completed and reported to QAPI committee.	

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F 880	Continued From page 11 port with the alcohol swab. NA-B then placed the catheter bag into a linen cover and hung the catheter bag from the bottom of R32's bed. placed cath bag in a linen cover. During an interview with NA-B and licensed practical nurse (LPN)-A on 8/17/23 at 8:36 a.m., NA-B stated an uncovered catheter bag lying on the floor increased the risk of infection. Additionally, a catheter drainage port should be cleaned prior to opening to prevent infection. During an interview on 8/17/23 at 10:30 a.m. the director of nursing (DON) stated R27's catheter bag and cares should be done in a manner to prevent the transmission of infection. The facility policy Catheter Associated Urinary Tract Infection (CAUTI) Prevention last reviewed 5/22/23, directed staff to use standard precautions when handling a urinary catheter and/or urine collection system. This included hand hygiene before and after catheter cares or manipulation/emptying of the urinary collection system and donning clean exam gloves prior to catheter care or emptying the urine collection system. However, the policy did not address where the catheter bag should be kept and/or to keep the catheter bag off the floor.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883		9/20/23

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F 883	Continued From page 12 receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		

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F 883	Continued From page 13 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 4 of 5 residents (R14, R20, R27, R34) reviewed for immunizations. Findings include: R14's quarterly MDS dated 7/25/23, identified R14 was admitted to the facility on 4/21/23, was 89 years old and identified a diagnosis of diabetes. R14's Preventative Health Care immunization record undated, identified R14 received the PPSV23 on 10/6/04 and 20/20/19. R14's EHR did not include evidence R14 or R14's representative received education regarding pneumococcal vaccine booster and there was no indication R14 was offered the pneumococcal vaccine per CDC guidance. R20's quarterly MDS dated 6/27/23, identified R20 was admitted to the facility on 3/28/23, was 70 years old and identified diagnoses of hypertension and dementia. R20's Preventative Health Care immunization	F 883	Licensed staff were educated at time of survey on updated vaccine recommendations. 8/17/23 Vaccination consent/refusal form was developed to be completed on admission and reviewed annually or with immunization recommendation changes. Form includes education provided, vaccines recommended, and indicate if resident/resident representative is accepting or declining immunizations. R34: 8/21/23 reviewed VIS and pneumonia vaccine recommendations with him. He declined any additional vaccines at this time. R27: 8/22/23 spoke with his daughter on telephone regarding recommended vaccines to bring him up to date. She requested information be left in his room for her to pick up. She reported she would discuss with her mom and sister and let facility know if the would want any recommended vaccines given. 9/20/22 daughter undecided but stated will call prior to visit scheduled for pharmacist to be in facility to immunize all residents. R20: 70 yr old 8/22/23 spoke with daughter. Reviewed immunization history	

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F 883	Continued From page 14 record undated, identified R20 received the Pneumococcal conjugate vaccine (PCV13) on 10/27/15, and a PPSV23 on 11/16/21. R20's EHR did not include evidence R20 or R20's representative received education regarding pneumococcal vaccine booster and there was no indication R20 was offered the pneumococcal vaccine per CDC guidance. R27's significant change Minimum Data Set (MDS) dated 7/4/23, identified R27 was admitted to the facility on 3/30/22, was 91 years old, and included diagnoses of heart failure, hypertension and diabetes. R27's Preventative Health Care immunization record undated, identified R27 received the pneumococcal polysaccharide vaccine (PPSV23) on 11/29/04. R27's EHR did not include evidence R27 or R27's representative received education regarding pneumococcal vaccine booster and there was no indication R27 was offered the pneumococcal vaccine per CDC guidance. R34's quarterly MDS dated 6/27/23, identified R34 was admitted to the facility on 3/7/23, was 69 years old and and included diagnoses of hypertension and diabetes. R34's Preventative Health Care immunization record undated, identified R34 refused pneumococcal vaccination on 3/7/23. R34's EHR did not include evidence R34 or R34's representative declination for pneumococcal vaccine nor received education regarding pneumococcal vaccine. Additionally, R34's EHR lacked evidence R34 was offered or received education regarding influenza vaccine.	F 883	and what is recommended to bring him up to date. VIS for vaccines mailed to daughter. Daughter in agreement with him receiving any vaccines recommended by PCP and pharmacist. R20 received PCV13 on 10/27/15, PPSV23 on 11/16/01 and 11/21/19. 9/15/2023 Pharmacist reviewed vaccination history and does not recommend any additional pneumonia vaccines to at this time. Pharmacist recommends COVID, RSV, Flu, and shingles, tetanus to be given over next few months to bring him up to date. R14: 8/25/23 spoke with resident and his spouse. Both requested we speak with son. VIS mailed to son. 8/27/23 Spoke with son. Reviewed & discussed recommended vaccines with him. Son declined any vaccines given at this time but said he would talk to his parents and siblings. He is concerned about him receiving any vaccines due to recent decline in his health. 8/17/23 For all resident in facility, new vaccination consent/refusal form was used to review all resident records to review vaccine history and determine if any vaccines were needed to bring residents vaccination status up to date with current recommendations for Flu, RSV, COVID, Pneumonia, Tetanus, and Shingles. Information was given to and reviewed with any residents who make their own decisions. For residents that do not sign for themselves, 8/24/23 forms were mailed to each resident's representative to notify of the resident's specific recommended vaccinations and	

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F 883	Continued From page 15 During an interview on 8/16/23 at 4:05 p.m. director of nursing (DON) stated she was responsible for the facility's infection prevention program, before taking the DON position. The facility works with a local pharmacy to provide immunizations for the residents and were aware of pneumococcal vaccination recommendation changes; however, had reviewed immunization records for new admissions only. The plan was to offer immunizations in the fall during the influenza immunization clinic. The DON stated immunizations were important for the prevention of communicable disease transmission. The facility provided Vaccine Information Statement (VIS) Pneumococcal Conjugate Vaccine dated 5/12/23, and Pneumococcal Conjugate Vaccine (PCV13) dated 10/30/19, identified education regarding the need for PPSV23 and Prevnar 13. The facility policy SNF Vaccination of Residents - Influenza, Pneumococcal and COVID-19 undated, instructed staff to review vaccination history for all residents at the time of admission and to document in the preventative health section of the EMR. Additionally, the policy directed staff to administer pneumonia vaccines as appropriate. However, the policy did not provide staff direction upon resident or resident's representative vaccine declination.	F 883	included education on recommended vaccinations. Self addressed stamped envelope was included for consents/declinations to be returned. Onsite review of vaccines and VIS were completed to resident representative who were in facility while RN available. 1 week prior to scheduled pharmacist vaccination visit, nurse contacted resident representative for any forms that have not been returned. Signed documentation will be scanned into EHR. Nurse documented consent, declination, and education given for each vaccine recommended for each individual resident. Requested the current Risk vs Benefit progress note template to be edited to include vaccine section with all necessary documentation. Until template is created, nurse will document in progress note the above information. Will continue to complete the vaccination consent/refusal form on all new admissions until comparable tool is built in Matrix. Audits completed monthly to verify all residents are either up to date with vaccinations or there is documentation of declination of recommended vaccinations. Audits will continue until all current resident/resident representative made decision and facility has documented acceptance or declination of vaccines. New admissions will be audited for	

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F 883	Continued From page 16	F 883	up-to-date vaccination status and offered any recommended vaccines to bring them up to date. All residents will be reviewed annually and when CDC updates immunization recommendations. Audit results will be reported to QAPI for review. Director of Nursing responsible for ensuring audits are completed and reported to QAPI committee.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 7, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: OXL311

Dear Administrator:

The above facility was surveyed on August 14, 2023 through August 17, 2023 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

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

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00461	A. BUILDING: _____ B. WING _____	08/17/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/14/23 through 8/17/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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. 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	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.	2 302		9/8/23

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	00461	A. BUILDING: _____ B. WING _____	08/17/2023

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2 302	Continued From page 3 (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure staff completed the required annual Alzheimer's and dementia training for 4 of 5 staff (NA-C, NA-G, NA-H, DA-A) reviewed for dementia care. Findings include: Alzheimer's disease or related disorder training was requested for nursing assistant (NA)-A, NA-G, NA-H and dietary aide (DA)-A. However, none of the training documents were received. During interview on 8/17/23 at 11:25 a.m., director of nursing (DON) stated Alzheimer's training was required annually and upon new hire for all the direct and non-direct care staff. The facility used HCI Interactive Dementia training for staff education. Reports identifying the staff name and completed training could be pulled from the	2 302	CORRECTED	

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2 302	Continued From page 4 website; however, the DON stated she was unable to see or pull the report for staff. The facility provided an undated learning objectives on Alzheimer's training and indicated staff would be able to describe and give examples of dementia-related behavior, understand how dementia affected a person's behavior, list common causes of dementia-related behavior and explain why it was important to pay attention to the behavior of a person with dementia. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure all required areas of Alzheimer's training were covered for all staff; educate all appropriate staff on the policies and procedures; and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 550	CORRECTED	8/21/23

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2 550	Continued From page 5 facility failed to accurately code the hospice status on the Minimum Data Set (MDS) for 1 of 1 residents (R28) reviewed hospice services. Findings include: R28's quarterly MDS dated 6/27/23, identified R28 had diagnoses that included chronic kidney disease, hypertensive heart disease, and legal blindness. The MDS failed to identify R28 received hospice care in section O- Special Treatments and Programs. R28's care plan dated 7/24/23, identified R28 received hospice services due to end stage heart failure. During an interview on 8/16/23 at 3:28 p.m., registered nurse (RN)-A stated she missed entering R28's hospice services and had been on hospice services for awhile. During an interview on 8/16/23 at 4:03 p.m. the director of nursing (DON) stated R28 was on hospice for some time. The DON stated MDS assessment accuracy was important because it drove payment, staffing needs and was basis for everything long term care related. The facility policy Minimum Data Set revised 6/14/21, identified the MDS was a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing home resident to provide the facility with the information necessary to develop a care plan and to provide appropriate care and services for each resident and to modify the care lan and care/services based on resident status. Staff were directed to refer to the Resident	2 550		

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2 550	Continued From page 6 Assessment Instrument (RAI) manual for further instructions, definitions and guidance. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately completed. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow care planned interventions to prevent falls for 1 of 1 residents (R27) reviewed for falls.	2 830	CORRECTED	9/15/23

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2 830	Continued From page 7 Findings include: R27's significant change Minimum Data Set (MDS) dated 7/4/23, identified R27 had severe cognitive impairment and required extensive assistance to total dependence for all care areas. Diagnoses included dementia and a history of falling. R27's falls Care Area Assessment (CAA) dated 7/17/23, identified R27 was a high fall risk and balance concerns. R27's contributing factors included: advanced age, impulsiveness, forgetfulness, R27 did not think that he needed help, cancer, urinary catheter, multiple falls reported prior to admit to facility with compression fractures and since admit he had continued to have multiple falls, one with fracture to hip that was most recent this summer, and taking an antidepressant and a diuretic. This placed R27 at risk for more falls, minor or serious injury, and possible need for re-hospitalization. R27's care plan dated 6/12/23, included interventions of fall mat at bedside (keep bed at knee height) and also for the bed to be at knee height rather than to the floor due to cathether bag touching floor. During an observation on 8/15/23 at 12:44 p.m. R27 was lying in bed with the bed in the lowest position. On 8/17/23 at 7:57 a.m., R27 was observed lying in bed. R27's room was darkened but R27 was clearly visible from the hallway. R27's bed was in the lowest position with a mat on the floor next the bed. R27 was curled up on his left side, facing the hallway.	2 830		

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2 830	Continued From page 8 On 8/17/23 at 8:23 a.m., nursing assistant (NA)-B entered R27's room and stated R27's bed should not be in the low position and pointed to a piece of tape that was taped to the wall near R27's headboard. NA-B then raised R27's bed so that it was equal in level to the tape. On 8/17/23 at 8:36 a.m., licensed practical nurse (LPN)-A entered R27's room to assist NA-B with cares. LPN-A stated R27's bed not being at the correct care planned height could increase R27's risk for falls. During an interview on 8/17/23 at 10:30 a.m., the director of nursing (DON) stated R27's care plan was updated after his fall with major injury in June 2023. Saff placed tape near the headboards of all residents' beds for staff to have a quick reference at what height the bed should be to lessen confusion. As always, the staff should follow the care plan and leadership was trying to break staff going by memory or verbal report. Staff should always ask if they are not sure or use the care plan that is posted in every resident's closet. The facility policy Fall and Fall with Injury Risk Assessment, Prevention and Management for Hospital and Ambulatory Settings reviewed 5/3/23, identified the facility's guiding principle was that all residents were at risk for falls. Universal Fall Precautions/Low Risk Interventions always applied to every resident. The registered nurse would use the fall risk assessment and risk for injury screeening tools to individualize the resident's care plan to reduce the risk of falls and/or fall-related injuries. The tools would be used to the assist the RN in the selection of appropriate risk reduction interventions to implement.	2 830		

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2 830	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The DON or designee could train all staff of individualized fall interventions. The DON or designee could complete audits to ensure compliance and bring the results to the quality assurance team. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper catheter care was provided to prevent infection for 1 of 3 residents (R27) reviewed for catheter. Findings include: R27's significant change Minimum Data Set (MDS) dated 7/4/23, identified R27 had severe cognitive impairment and utilized an indwelling urinary catheter. Diagnoses included dementia, diabetes and cancer. R27's care plan dated 6/12/23, identified R27 used an indwelling urinary catheter due to	21385	CORRECTED	9/15/23

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21385	Continued From page 10 obstructive uropathy (a condition of excess urine accumulation in kidney(s) that causes swelling of kidneys). Staff were directed to empty R27's catheter bag each shift and as needed. Record output total and appearance. During an observation on 8/17/23 at 7:57 a.m. R27 was lying in bed with his uncovered catheter bag lying on the floor. At 8:23 a.m., nursing assistant (NA)-B entered R27's room and stated R27's catheter bag should not be lying on the floor without a protective barrier such a bag cover. - At 8:13 a.m., NA-A applied a gown and gloves and gathered supplies to perform catheter care for R27. - At 8:27 a.m., NA-B picked up R32's catheter bag, placed paper towels on the floor and attempted to open the drainage port. However, NA-B stated she was unable to open the port and stated she needed the nurses' assistance. - At 8:30 a.m., NA-B opened an alcohol swab but laid it on it R32's bed. - At 8:32 a.m. licensed practical nurse (LPN)-A entered R32's room to assist NA-B. LPN-B applied a gown and gloves, then demonstrated the opening of the drainage port to NA-A. However, neither LPN-A nor NA-A cleaned the drainage port with the alcohol swab prior to opening the port. - At 8:35 a.m., once the catheter bag was empty, NA-B closed the drainage port and cleaned the port with the alcohol swab. NA-B then placed the catheter bag into a linen cover and hung the catheter bag from the bottom of R32's bed. placed cath bag in a linen cover. During an interview with NA-B and licensed practical nurse (LPN)-A on 8/17/23 at 8:36 a.m., NA-B stated an uncovered catheter bag lying on	21385		

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21385	Continued From page 11 the floor increased the risk of infection. Additionally, a catheter drainage port should be cleaned prior to opening to prevent infection. During an interview on 8/17/23 at 10:30 a.m. the director of nursing (DON) stated R27's catheter bag and cares should be done in a manner to prevent the transmission of infection. The facility policy Catheter Associated Urinary Tract Infection (CAUTI) Prevention last reviewed 5/22/23, directed staff to use standard precautions when handling a urinary catheter and/or urine collection system. This included hand hygiene before and after catheter cares or manipulation/emptying of the urinary collection system and donning clean exam gloves prior to catheter care or emptying the urine collection system. However, the policy did not address where the catheter bag should be kept and/or to keep the catheter bag off the floor. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		

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	245512	A. BUILDING **01 - NURSING HOME** B. WING _____	**08/16/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/16/2023. At the time of this survey, First Care Living Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 09/18/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Essentia Health NH is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(111) construction. In 1997, additions to the sleeping rooms and an activates room to the north east corner were constructed. Theses additions are Type II(111) construction. The building is divided into 4 smoke zones with a 30 minute and two 2-hour fire barriers.	K 000		

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K 000	Continued From page 2 The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems . The facility has a fire alarm system with smoke detection in the corridor system, in all sleeping rooms and in common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" . The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system. The facility has a capacity of 50 beds and had a census of 34 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		8/20/23

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K 321	Continued From page 3 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/16/2023 at 1213pm, it was revealed by observation that room 188 is currently being used for storage, did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	In compliance as of 8/20/23 – Maintenance installed auto closure on door. Facility supervisor responsible.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	K 372		8/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING **01 - NURSING HOME** B. WING _____	**08/16/2023**

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

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K 372	Continued From page 4 fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 08/16/2023 at 1137 am it was revealed by observation that there was a penetration running from one smoke compartment to another above doors next to Administration office 208. 2) On 08/16/2023 at 1145 am it was revealed by observation that there was a penetration running from one smoke compartment to another above North Lobby Fire Doors. 3) On 08/16/2023 at 1154 am it was revealed by observation that there was a penetration running from one smoke compartment to another along smoke wall in room 113 - West Wing. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 372	In compliance as of 8/16/23 – All penetrations have been fire caulked. Staff were educated. The plan is to inspect behind all vendors breaching smoke or fire barriers. Facility supervisor responsible.	

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K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/16/2023 at 11:15, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report. An interview with the Director of Maintenance verified this deficient finding at the time of discovery	K 521	In compliance as of 9/15/23 – Staff completed a fired damper inspection and documentation saved. The inspection was added to an automatic system to ensure future inspections are not missed. Facility supervisor responsible.	9/15/23
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of	K 711		8/17/23

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K 711	Continued From page 6 an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 08/16/2023 between 10:00 am and 01:30 pm, it was revealed in a review of available documentation that the facility failed to properly exercise their fire safety plan during a fire incident on 06/18/2023. During said fire incident facility failed to contact the Authority Having Jurisdiction (AHJ) = State Fire Marshals Office and report incident as stated in facilities Fire Evacuation Plan. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 711	In compliance as of 8/17/23 – Educated administration and maintenance staff to ensure Fire Marshall is called for every fire event. Facility supervisor responsible.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		9/15/23

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K 914	Continued From page 7 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 08/16/2023 at 11:30am, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey.	K 914	In compliance as of 9/15/23 – Testing was conducted by maintenance personnel. Testing was added to an automated system to alert staff to complete the test annually. Facility supervisor responsible.	

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K 914	Continued From page 8 An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 914		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245512	MULTIPLE CONSTRUCTION A. BUILDING: **01 - NURSING HOME** B. WING _____	DATE SURVEY COMPLETE: **8/16/2023**

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 162	Roofing Systems Involving Combustibles CFR(s): NFPA 101 Roofing Systems Involving Combustibles 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. Roof covering meets Class C requirements. 2. Roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2 1/2 inches concrete or gypsum fill. 3. Attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain non-combustible ceiling in accordance with the NFPA Life Safety Code 101 2012 edition section 19.1.6.3 subsection 1 and 3. This deficient practice could have an isolated impact on the residents within the facility. Findings include: On 08/16/2023 at 1202 pm, it was revealed by observation that records storage room was missing ceiling tiles. Ceiling tiles were replaced at time of survey. An interview with Maintenance Director verified these deficient findings at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents