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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VYUH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00936

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245319**

2.STATE VENDOR OR MEDICAID NO.
(L2) **486728900**

3. NAME AND ADDRESS OF FACILITY
(L3) **LA CRESCENT HEALTH SERVICES**
(L4) **101 SOUTH HILL STREET**
(L5) **LA CRESCENT, MN** (L6) **55947**

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) **04/01/2006**

6. DATE OF SURVEY **06/28/2021** (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)
12/31

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (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
	42			
(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 :
Jennifer Kolsrud Brown, Unit Supervisor — 07/02/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 07/02/2021 (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
07/01/1986
(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.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/09/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 2, 2021

CMS Certification Number (CCN): 245319

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

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 June 4, 2021 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K0521.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

PLEASE NOTE THAT THE HEALTH AND LIFE SAFETY CODE SURVEYS WERE PROCESSED IN SEPERATE ENFORCEMENT CYCLES.

Electronically Delivered
July 2, 2021

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: CCN: 245319
Cycle Start Date: April 22, 2021

Dear Administrator:

On June 28, 2021, the Minnesota Department of Health 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

PLEASE NOTE THAT THE HEALTH AND LIFE SAFTETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE SURVEY CYCLES.

Electronically Delivered
June 28, 2021

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: CCN: 245319
Cycle Start Date: March 24, 2021

Dear Administrator:

On June 8, 2021, the Minnesota Department of 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.

Your request for a continuing waiver involving the deficiency(ies) cited under K0521 at the time of the March 24, 2021 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VYUH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00936

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2.STATE VENDOR OR MEDICAID NO.
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(L3) **LA CRESCENT HEALTH SERVICES**
(L4) **101 SOUTH HILL STREET**
(L5) **LA CRESCENT, MN** (L6) **55947**

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) **04/01/2006**

6. DATE OF SURVEY **04/22/2021** (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**	
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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: B5* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(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 :
Nicole Briley, HFE NE II 05/28/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 06/04/2021 (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
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(L44)
B. Rescind Suspension Date:
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26. TERMINATION ACTION: (L30)
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07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 13, 2021

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: CCN: 245319
Cycle Start Date: April 22, 2021

Dear Administrator:

Please Note: The Health and Life Safety Code survey findings were processed under separate enforcement cycles.

On April 22, 2021, a survey was completed at your facility by the Minnesota Departments of Health 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 22, 2021 (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 October 22, 2021 (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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(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 4/19/21-4/22/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:]	E 035		6/4/21

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

Electronically Signed | 05/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(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 035	Continued From page 1 (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a communication plan, which included a method for sharing appropriate information from the emergency plan that the facility had determined was appropriate with residents, families or representatives. This had the potential to affect 23 residents currently residing in the facility, as well as staff and visitors. Findings include: During an interview on 4/22/21 at around 4:30 p.m., the administrator stated emergency preparedness is discussed at resident council and the binder is available in the lobby area. Administrator stated that the emergency plans are not included in the admission packet nor have they been given to residents or families. Facility emergency operations plan did not include a communication plan that included a method for sharing appropriate information from the emergency plan to residents, families or representatives.	E 035	No specific resident was identified Residents, staff, and visitors have the potential to be impacted by this practice. Review of the Emergency Operations Plan was completed on 05/20/2021 and communication plan was identified to include information being shared at admission and through on-going communication in the event of an emergency. The plan further identified agencies that may be used to assist the facility in communicating status to residents and families such as the Ombudsman, Public Health Officials, and the American Red Cross. General information on the facility's emergency plans and the communication plan was added to the admission packet and the Executive Director completed a letter to families and residents notifying them of the plan and of the possible forms of communication during an emergency or natural disaster. An Emergency Operations Plan binder was placed in the common area to allow ease of access should a family member or resident desire additional information on specific emergency protocols. Letters were completed on 05/21/2021 and mailed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

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E 035	Continued From page 2	E 035	The Executive Director received education from the Director of Clinical Services on the Emergency Operations Plan communication plan on 05/20/2021. The Executive Director or designee will review new admission files weekly for eight weeks to ensure the Emergency Operations Plan communication notice is shared with residents and families at admission Audits will begin on or before 06/01/2021 and be continued weekly for eight weeks with results of audits to the Quality Assurance committee for review and recommendations.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(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 037	Continued From page 3 (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(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 037	Continued From page 4 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		

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E 037	Continued From page 5 staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection,	E 037		

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E 037	Continued From page 6 and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide annual training for new and current staff regarding policy and procedures in the facility's emergency preparedness plan. This had the potential to affect all 23 residents currently residing in the facility, as well as staff and visitors.	E 037	No specific resident was identified Residents, visitors, and staff have the potential to be impacted by this practice. Emergency Operations Plan binders were placed at nursing station and in the common area for ease of access to review as needed.	

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E 037	Continued From page 7 Findings include: During an interview on 4/22/21 at around 4:30 p.m., the administrator was unable to provide documentation of education provided to staff regarding emergency preparedness or the facility emergency plan. Administrator stated staff participate in exercises of various emergencies but have not been given the emergency operations plan to review. Facility emergency operations plan indicated education and training, including drills and exercises are utilized in the facility to achieve proficiency during emergency response and the facility conducts initial training on the emergency operations plan during orientation of new staff and annually to all staff or as needed if the emergency operations plan is changed. It included that a disaster drill is held bi-annually in which one will be community based. It included a written report of drills and exercises is maintained.	E 037	The Executive Director will provide education to facility staff beginning 5/21/2021 on the emergency operations plans for events that have the potential to occur in or near the facility and the process that will be followed for communication with staff during an emergency or natural disaster. The Executive Director or designee will audit staff's understanding of the Emergency Operations Plan through direct interviews weekly for eight weeks. Audits will begin on or before 06/01/2021 and be continued weekly for eight weeks with results of audits to the Quality Assurance committee for review and recommendations.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises	E 039		6/4/21

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E 039	Continued From page 8 to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct	E 039		

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E 039	Continued From page 9 exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual	E 039		

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	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

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E 039	Continued From page 10 facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that	E 039		

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E 039	Continued From page 11 requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community	E 039		

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E 039	Continued From page 12 based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next	E 039		

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E 039	Continued From page 13 required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

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E 039	Continued From page 14 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 15 (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]:	E 039		

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E 039	Continued From page 16 (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure they conducted exercises to test their emergency plan at least annually, including participation in a full scale and tabletop exercises. Findings include: During an interview on 4/22/21 at around 4:30 p.m., the administrator stated the last tabletop and full-scale exercise were completed in 2019. The administrator was unable to provide documentation of the last full scale or tabletop exercise. The administrator stated they just completed a tabletop fire drill on 4/22/21 and have a full-scale tornado exercise scheduled the following week. The administrator stated the facility did have an actual outbreak of covid in November 2020 and utilized the emergency plan. Facility emergency operations plan indicated education and training, including drills and	E 039	No specific resident was identified. Residents, visitors, and staff have the potential to be impacted by this practice. The facility had planned to attend a statewide tornado exercise on April 23, 2021. This event was cancelled. The Executive Director is working with county representatives to request a new date for this exercise. If there is not a county or state level exercise prior to June 4, 2021, the facility will conduct a tornado drill in house and provide education to staff. The Executive Director and the Director of Nursing were educated on May 20, 2021 by the Director of Clinical Services on completing a full- scale disaster drill in house. The Maintenance Supervisor or designee will audit staff's understanding of	

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	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

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E 039	Continued From page 17 exercises are utilized in the facility to achieve proficiency during emergency response and the facility conducts initial training on the emergency operations plan during orientation of new staff and annually to all staff or as needed if the emergency operations plan is changed. It included that a disaster drill is held bi-annually in which one will be community based. It included a written report of drills and exercises is maintained.	E 039	emergency response plan through direct interview with staff regarding response to a tornado, thunderstorm, or fire event. Audits will begin on or before 06/01/2021 and be continued weekly for eight weeks with results of audits to the Quality Assurance committee for review and recommendations.	
F 000	INITIAL COMMENTS On 4/19/21-4/22/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H5319047C (MN49743), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5319046C (MN52767), H5319048C (MN70028), H5319049C (MN61592), H5319050C (MN61159), H5319051C (MN61113). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	F 000		

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	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

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F 000	Continued From page 18 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to assess safety and effectiveness for assisted device used for positioning and comfort implemented following a fall for 1 of 1 resident (R)7 reviewed for accommodation of needs. Findings include: R7 Minimum Data Set (MDS) assessment dated 2/1/21 indicated moderately impaired cognition, bed mobility extensive assistance of two persons physical assist, no impairment of upper and lower extremities, uses wheelchair, dependent on rolling to sides and sitting up, no restraints, and no falls indicated. R7 admission record indicated diagnoses of dementia and muscle weakness.	F 558	R 7 had positioning pillow removed on 4/22/2021 and a perimeter mattress placed. Pillows were placed to assist with positioning. Care plan and task list were reviewed and updated. Residents who use devices to assist with positioning have the potential to be impacted by this practice. Care plans, task lists, and assessments were reviewed beginning May 19, 2021, for these residents and updated as needed to reflect current needs. The Director of Nursing or designee will present education beginning 05/24/2021 to licensed nurses on completing assessments quarterly and with significant changes for assistive devices.	6/4/21

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F 558	Continued From page 19 During an observation on 4/19/21 at 7:00 p.m., surveyor observed large U shaped device on mattress under fitted sheet for R7. The U shape part of the device was at head of bed with a standard sized pillow placed on top and underneath the standard pillow was observed an open like space in the center. The device laid along the perimeter of bed about three quarter towards the foot of the bed. R7 care plan indicated impaired communication due to impaired cognition, rarely communicates her needs and rarely understands others. Care plan also indicated at risk for falls related to cognition and weakness. Interventions included call bell within reach, pillow for positioning, fall mat on both sides of bed, bed in lowest position; place body U shaped pillow tube for comfort and to provide defined perimeter of mattress; review information on past falls and attempt to determine cause of falls for prevention and to minimize injuries; wheelchair at bedside. Facility root cause analysis following R7 fall on 8/15/20 indicated R7 crawled out of bed over the u shaped pillow used to position for comfort. It indicated the root cause of R7 confusion, unable to understand safety risks due to dementia, lack of muscle coordination due to cerebral vascular accident, and crawled out of bed on own. Interventions placed following the fall included floor mats added to both sides of bed and bed in lowest position. It indicated no change from prior minimum data set (MDS). Facility Kardex report used by aides indicated under safety to place body u shaped pillow tube	F 558	The Director of Nursing or designee will complete audits weekly of quarterly assessments for assistive devices for eight weeks. Audits will start on or before 06/01/2021. Results of audits will be forwarded to the Quality Assurance committee for review and recommendations.	

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F 558	Continued From page 20 for comfort and to provide defined perimeter of mattress. R7's record did not include an assessments for risk or usage of assisted devices for positioning or comfort such as the U shaped body pillow and no re-evaluation for effectiveness of u shaped body pillow since implemented in 2019. During an interview on 04/19/21 at 06:36 p.m., nurse aide (NA)-C stated R7 does not talk much and is difficult to understand. NA-C stated R7 will answer yes and no. NA-C stated R7 sleeps with U shape body pillow at night that is under sheets on the mattress and has fall mats on each side of the bed. NA-C stated R7 is repositioned every couple of hours. During an interview on 04/21/21 at 09:04 a.m., NA-A stated R7 has history of rolling out of bed and has the positioning body pillow and fall mats in place. During an interview on 04/22/21 at 07:47 a.m., RN-B stated body pillow is used for positioning and has been in place since she fell out of bed a while ago. During an interview on 04/22/21 at 10:10 a.m., registered nurse (RN)-C stated the body pillow is used like a mattress with a lip. RN-C stated it was put in place following a fall. RN-C stated R7 can move in bed depending on the day. RN-C stated R7 mostly needs assistance with repositioning side to side when in bed. RN-C stated the body pillow helps with positioning and helps keep on side but also effective to help keep her safe. RN-C stated the body pillow does not	F 558		

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F 558	Continued From page 21 prevent R7 from moving. During an interview on 04/22/21 at 10:52 a.m., NA-D stated the body pillow is used for positioning and to help prevent R7 from rolling out of bed. NA-D stated staff reposition R7 every 2 hours in the night. NA-D stated R7 does move extremities but has not seen R7 reposition herself while in bed. NA-D stated R7 will position self up on elbows. NA-D stated R7 use to be more active and move around but has not been lately. During an interview on 04/22/21 at 11:32 a.m., director of nursing (DON) stated the U shaped body pillow is used to position and help keep her on her sides. DON stated the u shaped body pillow was not considered a restraint. DON stated the pillow was initiated after a fall for position and comfort. DON stated the body pillow use has not been re-evaluated or re-assessed since put in place in 2019. DON stated R7 is dependent on staff for repositioning. DON stated she made reference to the body pillow as a positioning device following R7 fall out of bed in August 2020 where R7 did roll out of bed with the body pillow in place. During an interview on 04/22/21 at 04:54 p.m., RN-A stated the u shaped body pillow was initiated as a positioning device following a fall in 2019. RN-A stated there has not been an assessment or evaluation for the safety or effectiveness for the use of this pillow for R7. RN-A stated after personally viewing the pillow placed under the sheets on the mattress, she understood the potential safety issue for R7 and decided to discontinue the use and have staff	F 558		

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F 558	Continued From page 22 utilize pillows for repositioning and comfort. Facility falls prevention and management guidelines policy and procedure revision dated 3/10/21 indicated assessments that may assist with identification of fall risk, potential hazards, and interventions to prevent falls or minimize injuries included clinical assessments and environmental assessments of assistive devices. The procedure included review of falls and safety quarterly of proper use of assistive devices and individual interventions defined in care plan. When asked for policy on assisted devices for positioning or comfort. None were received	F 558		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages	F 576		6/4/21

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F 576	Continued From page 23 and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility who received personal mail, including but not limited to 4 of 4 residents (R1, R2, R3, R11) at the resident council meeting, who verbally confirmed not receiving mail on Saturdays. This has the potential to effect all 23 residents living in the facility. Findings include: On 4/21/21, at 10:00 a.m. a group of residents met to discuss the resident council. When asked whether residents received their mail on Saturdays, all four residents voiced they did not receive their mail on Saturdays. The residents shared the activity director (AC) did not work on	F 576	No specific resident was identified. Residents who receive mail on Saturdays have the potential to be impacted by this practice. Manager on Duty responsibility list was created on May 20, 2021, to include mail delivery on Saturday. The Executive Director will educate the Manager on Duty team on May 21, 2021, regarding the need to deliver mail on Saturdays as part of the routine duties when working on Saturdays. The Executive Director or designee will complete weekly resident interviews regarding mail delivery on Saturday for eight weeks. Audits will start on or before	

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F 576	Continued From page 24 Saturdays and the AC was the person who delivered the mail. The residents shared they would get their mail delivered on a Saturday if the AC worked that day. During an interview on 4/21/21, at 2:51 p.m. the administrator stated we do have a manager on duty that works the weekends. The administrator stated he expect that mail be delivered six days a week. During an interview on 4/22/21, at 1:12 p.m. the administrator stated it was also his expectation that residents receive mail in a prompt manner. A policy on resident mail was requested and not provided. The Combined Federal and State Bill of Rights revised 6/18/19 included, "The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service."	F 576	06/01/2021. Results of audits will be forwarded to the quality assurance committee for review and recommendations.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		6/4/21

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F 584	Continued From page 25 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 7 of 7 resident rooms (RM 207, 208, 210, 211, 216, 217, 219) were not	F 584	Repairs have been or will be completed in rooms 209 and 210. Toilet riser and rim were cleaned in 211. Estimates have	

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F 584	Continued From page 26 maintained in a safe, clean and homelike environment. Findings include: During an observation on 4/19/21 at 1:30 p.m., room 210 had a strong urine odor upon entering the room. Tiles were missing underneath bed, food on the chair and floor. Bathroom also had a very strong urine odor, toilet had dried feces on inside of bowl and floor tiles were lifted at the edges and had an uneven surfaces. During an interview and observation on 4/19/21 at 1:50 p.m., room 211 toilet riser and rim of toilet were soiled, dust and hair on toilet rim. Windows were dirty with cobwebs and dead bugs. During an observation on 4/20/21 at 9:50 a.m., room 211 toilet remained dirty and dusty. During interview and observation on 4/21/21 at 12:34 p.m., Maintenance Director (MAINT) - A verified room 209 flooring was missing tiles underneath the bed and tiles in the bathroom were replaced about a year ago and were now lifting at the edges creating an uncleanable surface. During an observation on 4/21/21 at 1:16 p.m., room 211 rim of toilet remains dirty, dusty and windows remained cobwebs and dead bugs in the sills. During interview and observation on 4/21/21 at 2:40 p.m., administrator verified it was a safety hazard to have floor tiles missing under the bed as well as flooring in the bathroom curling at the	F 584	been requested and are being completed for flooring in the identified bathroom. Window cleaning and repairs have been initiated for rooms 207, 208, 210, 211, 217 and 219. Residents have the potential to be impacted by this practice. Maintenance Supervisor and Environmental Supervisor are inspecting windows and floors in each room to ensure areas are identified and repaired. Cleaning guidelines for bathrooms were reviewed and did not require revision. The Executive Director will review expectations for inspection and repairs with the Maintenance Supervisor and Environmental Supervisor on 05/24/2021. The Environmental Supervisor will provide education to environmental services staff on cleaning resident bathrooms the week of 05/24/2021. The Executive Director of designee will complete audits through environmental rounds twice weekly for four weeks and then weekly for four weeks. Audits will start on or before 06/01/2021. Results of audits will be forwarded to the Quality Assurance Committee for review and recommendations.	

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F 584	Continued From page 27 edges. Administrator verified the windows were in need of cleaning due to buildup of cobwebs, dust and dead bugs. During an observation on 4/22/21 at 11:14 a.m., rooms 207, 208, 210, 211, 217, 219 had cobwebs and dead bugs in between window panes. Room 210 had a strong urine odor and room 216 had windows that would not close all the way, therefore, 2 cloth napkins were placed in between the window and the frame by resident (R)9. R9 stated maintenance placed the small pieces of foam around the window frame to help close the gap "a long time ago." An ant trap was also observed on the window ledge, no ants seen in room.	F 584		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding	F 693		6/4/21

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F 693	Continued From page 28 including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to check placement of gastrostomy tube (G-Tube) for 1 of 1 resident (R18) reviewed for tube feeding who has a history of pulling out the tube. Findings include: R18's Minimum Data Set (MDS) assessment dated 4/19/21 indicated R18 requires extensive assist of one for transfers, dressing, eating and bathing. R18's electronic medical record (EMR) indicated diagnoses of alcohol dependence, metabolic encephalopathy, aphasia, dysphagia, cognitive communication deficit, traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less. R18's progress note dated 4/18/2021 she was found in her room with the G-Tube laying on the blanket next to her. R18 was then sent to the ER where she was admitted as interventional radiology was required to replace tube. R18's dismissal summary indicated R18 has had multiple episodes of pulling the tube out. R18's care plan read to check tube placement for every feeding. During an observation on 4/20/21 at 1:19 p.m. R18 was found chewing on her tube feed tubing.	F 693	The Director of Nursing validated placement of R-18's enteral tube on 4/22/2021 upon learning RN-C had not completed this task. R-18 has received speech therapy services and is taking medication by mouth at this time. R-18 enteral feeding orders have been updated to include check placement prior to initiating tube feeding. Residents who receive medications through enteral tube have the potential to be impacted by this practice. The facility does not currently have additional residents with enteral tubes. Orders for enteral feeding or enteral medications for residents who admit with or acquire an enteral tube will include directions to check placement prior to administration of medications or enteral feeding. The Director of Nursing or designee provided/will provide education to licensed nurses on validating placement of enteral tube prior to administration of medications or enteral feeding. Education was initiated 05/21/2021. The Director of Nursing provided one to one education to RN-C on 04/22/2021 after RN-C reported to director she had not checked when she gave medications. The Director of Nursing or designee will	

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F 693	Continued From page 29 RN-C replaced tube feeding bag and tubing and taped tubing to the side of R18 abdomen. RN-C said R18's has a history of pulling her G-Tube out. RN-C did not check placement prior to setting up new feeding. During an medication administration observation on 4/21/21 at 7:11 a.m. RN-C failed to check placement. During an interview on 4/22/21 at 1:31 p.m., RN-C verified not checking for placement of G-Tube. RN-C stated, "I always check when I flush, but not every time when I do meds, probably should, just did not, little nervous." During interview on 04/22/21 01:54 p.m., Director of Nursing (DON) verified that G-Tube placement should be checked prior to being flushed, administering medications, tube feeding or if R18 had an issue or complaints of abdominal pain. DON verified RN-C received tube feeding education on 4/12/21. Facility Enteral Nutritional Therapy Policy dated June 2017 read check position of tube by placing stethoscope over stomach and instill a small amount of air into Enteral feeding tube. Listen for air to enter stomach.	F 693	complete direct observation of nurses administering enteral feedings weekly for eight weeks. Audits will start on or before 06/01/2021. Results of audits will be forwarded to the Quality Assurance committee for review and recommendations.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	C 04/22/2021

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F 757	Continued From page 30 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to offer and/or provide non-pharmacological interventions prior to administration of as needed (PRN) pain medications for 2 of 5 residents (R12, R229) reviewed for unnecessary medications. Findings include: R12's face sheet, identified R12 was admitted to the facility on 1/26/21 with diagnoses that included encounter for orthopedic aftercare following surgical amputation of left leg below the knee. R12's admission Minimum Data Set (MDS) assessment dated 2/9/21, identified R12 had moderate cognitive impairment and did not have rejection of care behaviors. The pain assessment portion of the MDS identified R12 had frequent	F 757	R-12 had a quarterly assessment, including pain assessment completed on 5/12/21. Orders were updated on 05/19/21 to include documentation of non-pharmacological pain interventions and pre and post pain scores. Order was clarified to include location of pain. R-229 orders were updated to include documentation of non-pharmacological interventions and pre and post pain scores and clarified to include location of pain. Residents who receive PRN pain medications have the potential to be impacted by this practice. Review of orders for current residents will be completed and orders updated as needed to include documentation of non-pharmacological interventions and	

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F 757	Continued From page 31 pain that did not interfere with sleep or limit his day-to-day activities, received scheduled pain medication, and PRN pain medication, and had not received non-medication interventions for the pain. The MDS further identified R12 was administered opioid pain medication during the assessment period. R12's care plan dated 2/16/21, included: Pain (Left BKA (below knee amputation) with a hard cast) evidenced by (verbal complaint of phantom pain) r/t (related to): amputation; bilateral inguinal hernia. The interventions included: -Will express that pain management is within acceptable limits -Adjust times of ADL and treatment activities so that occur after analgesic benefits have been achieved (i.e. therapy, wound dressing changes, etc.) -Administer pain medication per MD orders - Encourage/Assist to reposition frequently to position of comfort -Implement non-drug therapies (reposition, watching TV) to assist with pain and monitor for effectiveness. -Notify MD if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective. -Report GI distress secondary to analgesia such as nausea, constipation, diarrhea -Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. -Therapy eval and treat as ordered. R12's medication administration record (MAR) included: -Oxycodone (opioid pain medication) 5 mg Give	F 757	pre and post pain scores. The Director of Nursing or designee will provide education to licensed nurses on documenting pain interventions and pre and post pain scores. Nurses will be educated on the location of pain being included in the pain medication order and will understand this is the reason the resident is receiving PRN pain medications. Education will begin the week of 05/24/2021. The Director of Nursing or designee will audit documentation of PRN pain medication to ensure compliance with the use of non-pharmacological interventions and the entry of pre and post medication pain scores. Audits will begin on or before 06/01/2021 and will be completed three times weekly for four weeks then weekly for four weeks. Results of audits will be forwarded to the Quality Assurance committee for review and recommendations.	

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F 757	Continued From page 32 2.5 mg by mouth every 4 hours as needed for increased pain give 2.5 mg 1/2 tab for pain rate of 3-5. Start date 3/12/21. -Oxycodone (opioid pain medication) 5 mg Give 5 mg by mouth every 4 hours as needed for pain, take whole tablet for pain rate of 6-10. Start date 3/12/21. -acetaminophen tablet 500 mg, give two tablets by mouth every 6 hours as needed for pain, headache, or fever. Start date 2/4/21. R12's eAdmin (electronic medication administration) 4/21/2021, at 7:17 p.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify location or a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. R12's eAdmin (electronic medication administration) 4/21/2021, at 5:30 a.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. R12's eAdmin (electronic medication administration) 4/20/2021, at 7:46 p.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify location or a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated resident request. R12's eAdmin (electronic medication administration) 4/19/2021, at 6:27 p.m. indicated	F 757		

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F 757	Continued From page 33 R12 was administered 5 mg of Oxycodone. The record did not specify location or a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated resident request. R12's eAdmin (electronic medication administration) 4/18/2021, at 8:46 a.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify what aggravates or alleviates pain and lacked evidence non-pharmacological interventions were attempted or offered. Indicated pain was stabbing at times to left amputation site. R12's eAdmin (electronic medication administration) 4/16/2021, at 11:47 a.m. indicated R12 was administered 2.5 mg of Oxycodone. For a pain rating of a 6. The record did not specify location or a description, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated ½ tabs given per request. R12's eAdmin (electronic medication administration) 4/15/2021, at 8:16 p.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify location or a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated resident request. R12's eAdmin (electronic medication administration) 4/15/2021, at 8:11 a.m. indicated R12 was administered 2.5 mg of Oxycodone. For a pain rating of a 6. The record did not specify a	F 757		

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F 757	Continued From page 34 description of pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated 2 ½ tabs requested for left leg pain. R12's eAdmin (electronic medication administration) 4/13/2021, at 6:51 p.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated R12 complained of leg/stump pain. R12's eAdmin (electronic medication administration) 4/12/2021, at 6:41 p.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated R12 complained of left leg pain. During an interview on 4/20/21, at 2:51 p.m. registered nurse (RN)-D stated R12 can tell you when he was having pain. When asked to describe the process for administration of PRN pain medications, RN-D described the following process. RN-D would ask R12 to rate his pain, depending on his pain rate RN-D would determine the dose to give. Complete the five rights of medication administration, include time last received to ensure he can receive the medication. Then administer the medication. RN-D stated sometimes point click care [electronic medical system) will direct staff to complete a progress notes for the PRN. RN-D stated progress note would include pain rate and	F 757		

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F 757	Continued From page 35 description of pain. RN-D stated try to check back within 1.5 hours and document effectiveness on the MAR. RN-D stated "pain for R12 was worse during the night and R12 was not good about asking for PRN pain medication until it (pain) was really bad and then we will give him 5 mg (oxycodone)". RN-D did not mention offering R12 non-pharmacological interventions prior to administration of a PRN pain medication when she described the process she followed. When questioned specifically about non-pharmacological interventions being offered to R12 for pain, RN-D stated we have done ice and elevate his leg. RN-D stated they did not document non-pharmacological interventions offered or tried and stated we should. RN-D stated, "I can tell you I do not think I have ever seen R12 in bed with leg not elevated". During an interview and observation on 4/21/21, at 7:11 a.m. R12 was in his recliner with his legs elevated waiting to leave for an appointment. R12 stated pain was good this morning and described pain as nerve pain in legs when he did have pain. R12 stated they give him two strong pain pills, stated during the day his pain was good and around 7-7:30 p.m. at night was when the pain started and was really painful. R12 stated the staff did not offer non-pharmacological interventions. R12 stated he asked for the pain medications when, "I need it. I have too." R12 stated now she (staff who administers medications) just knows to bring two pain pills at 7:00 p.m. During an interview on 4/21/21, at 1:22 p.m. registered nurse (RN)-C stated usually during the day R12's pain was fine and stated he will ask for	F 757		

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F 757	Continued From page 36	F 757		

pain medication before he goes to bed. RN-C stated R12 had phantom pain, stabbing pain, and will jerk all over. RN-C stated she thought the only thing R12 got relief for the pain was with oxycodone. RN-C stated has not had scheduled oxycodone since he has been here. RN-C stated R12 waits until pain is unbearable almost and then he was wanting the oxycodone.

During an interview on 4/22/21, at 9:51 a.m. nursing assistant (NA)-B stated R12's pain management seems better than it was as R12 was having a lot of leg pain when first came. NA-B stated R12 was able to communicate his pain and if R12 said anything about pain we go and tell the nurse right away. NA-B stated she was not told of any non-pharmacological interventions for pain and was not aware of anything in particular that they have tried. NA-B stated we do reposition R12 and R12 will let us know when he wants to switch positions.

During an interview on 4/22/21, at 8:55 a.m. the director of nursing (DON) stated resident would have to ask or say they are in some kind of pain. The nurse would complete an assessment ask for rate of pain and location of pain and then review PRN orders of what they have available and follow up on the effectiveness. The DON stated staff do offer heat and cold packs, repositioning and any other things that may be listed on the care plans like diversion or activities. The DON stated for R12 non-pharmacological interventions included encourage repositioning for comfort, watching tv, distraction and diversion. The DON stated staff reposition any time they are in there (R12's room).

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F 757	Continued From page 37 During an interview on 04/22/21, at 9:01 a.m. registered nurse (RN)-A stated it was a standard of care that they (nursing staff) would offer non-pharmacological interventions. RN-A stated she would expect staff to document non-pharmacological interventions with residents with severely impaired cognition. RN-A stated she expected for an alert an orientated resident that request pain medication staff would ask clarifying questions, including would it help to be position in a different way and what precipitated the pain. Once we reviewed those items would provide the pain medications. R229's Minimum Data Set (MDS) assessment dated 4/13/21 indicated cognitive impairment, no behaviors, extensive assistance of 2 staff for activities of daily living, uses walker and wheelchair, occasionally incontinent of bladder, continent of bowel, frequent pain, history of falls, and diuretic, anticoagulant, antidepressant use. R229's admission record included diagnoses of unspecified fracture of right femur, difficulty walking, unsteadiness on feet, unspecified abnormalities of gait and mobility, weakness, age related osteoporosis, and chronic kidney disease stage 3. R229's care plan included: pain related to recent surgery with interventions of administer pain medication per physician orders, encourage to reposition frequently to position of comfort,	F 757		

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F 757	Continued From page 38 implement non-drug therapies such as watching television, read books and newspaper, and assist with repositioning for pain and monitor for effectiveness. R229's orders included Tylenol 1000 mg three times a day for pain, Tramadol 50 mg every 6 hours as needed for pain rated 6-10. Medication administration record indicated R229 received Tramadol 50 mg as needed on 4/10/21 two times, 4/11/21 two times, 4/13/21 two times, 4/14 two times, 4/15 three times, 4/16 two times, 4/17 once, 4/19 two times, and 4/20 two times. During record review R229's record did not indicate non-pharmacological interventions were offered prior to administering as needed pain medications. During an interview on 4/22/21 at 02:54 p.m., R229 said he gets scheduled Tramadol for pain and is used to taking it as he has taken it for several years for his spine. R229 stated nothing else helps his pain. During an interview on 4/22/21 at 03:02 p.m., licensed practical nurse (LPN)-A stated R229 has Tramadol as needed. LPN-A stated R229 thinks he is already getting the Tramadol and will ask him if he is having pain. LPN-A stated at night she will offer him an ice pack and he will lay down. LPN-A stated staff do not usually document non-pharmacological interventions offered. During an interview on 4/22/21 at 3:32 p.m., director of nursing (DON) verified Tramadol was	F 757		

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F 757	Continued From page 39 ordered as needed. DON stated non-pharmacological interventions are listed in the care plan but not documented prior to administering as needed pain medication.	F 757		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident care equipment was cleaned daily for 1 of 1 resident (R20) who utilized a continuous positive airway pressure (CPAP) machine. Findings include: During an interview on 4/19/21, at 2:06 p.m. R20 stated cleaning of his CPAP machine did not get done like it should and stated he did not think staff did a very good job of tracking that. R20 stated he would like staff to help him with the cleaning of his CPAP. The CPAP was machine sitting on nightstand next to the bed. R20's change of condition Minimum Data Set (MDS) assessment dated 3/30/21, identified R20 had intact cognition and did not have rejection of care behaviors. R20's physician orders included: Clean CPAP every AM with ozone sanitizing device every shift related to sleep apnea. Dated 12/21/10. During an interview 4/22/21, at 11:33 a.m.	F 908	Instructions for use of R-20's CPAP cleaning device were added to his chart and posted near the machine. Day shift nurses were educated that they must clean the device following the posted instructions daily. Order directions were revised to indicate licensed nurse must complete cleaning following posted instructions. Residents who use CPAP devices that require routine cleaning have the potential to be impacted by this practice. One resident who was recently admitted does use a CPAP and detailed orders for cleaning the device were entered into his admissions orders. The Director of Nursing or designee will provide education to licensed nurses on cleaning CPAP devices per physician orders. Formal education will be presented beginning no later than 05/24/2021. The Director of Nursing or designee will	6/4/21

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F 908	Continued From page 40 registered nurse (RN)-C stated R20 cleaned the CPAP himself and we just mark that it was done on the treatment administration record (TAR). During an interview on 4/22/21, at 11:37 a.m. registered nurse (RN)-B stated the CPAP comes up on the TAR for the nurses to clean and stated R20 had supplies in his room for cleaning the CPAP. RN-B stated to her knowledge she did not think R20 cleaned the CPAP himself. RN-B stated if R20 refused to allow cleaning the CPAP she marked on the TAR refused. During an interview on 04/22/21, at 11:41a.m. the director of nursing stated the nurses were responsible to clean R20's CPAP machine and stated this was on the TAR. A policy on cleaning resident care equipment was requested and not provided.	F 908	complete audits weekly for eight weeks to validate cleaning is completed on CPAP machines. Audits will begin on or before 06/01/2021. Results of audits will be forwarded to the Quality Assurance committee for review and recommendations.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of 1 resident room (Rm. 114) bathroom faucet was kept clean and in a state of good repair. Findings include: On 4/19/21, at 6:34 p.m. room 114 was observed. The bathroom faucet and handles had a thick	F 921	Faucet in room 114 will be replaced on or before 06/03/2021. Residents have the potential to be impacted by lime build up on faucets in the facility. An inspection of faucets in the facility for lime build up will be completed by the Executive Director or designee and removal or lime scale build up or	6/4/21

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F 921	Continued From page 41 whitish substance build up. During an interview on 4/22/21, at 10:08 a.m. housekeeper (H)-A stated every day she wiped down and cleaned the faucet and handles but there was so much corrosion we cannot get them clean. H-A stated she used a pumice scouring stick and could not get it clean. H-A stated she reported this concern to maintenance and the housekeeping supervisor and was told it was from the hard water and I should keep working on it. During an interview on 04/22/21, at 10:15 a.m. the account manager health care services group (AMHCSG) stated he was aware of the condition of some of the faucets and stated we have really hard water in this building and the Lyme build up was from the hard water. The AMHCSG stated we have talked about replacing faucets. AMHCSG observed the bathroom faucet in room 114 and stated the Lyme build up was not acceptable. During an interview on 4/22/21, at 10:21 a.m. the administrator stated he had not been in the bathroom of room 114 before. The administrator stated if not able to remove the Lyme build up the facility should look at replacing the faucet. The administrator stated he would rely on the maintenance director's recommendation.	F 921	replacement of faucets will be scheduled based on results of inspection. Inspections will be completed no later than 06/03/2021. The Executive Director will provide education to environmental service and maintenance staff on reporting lime scale build up on faucets when noticed so the concern can be addressed timely. Education will be provided the week of 05/24/2021. The Executive Director or designee will complete audits of faucets monthly going forward as the facility is known to have hard water and the recurrence of lime scale build up is likely. Results of audits will be shared with appropriate departments for action and resolution of any lime scale build up.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2021

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

Re: State Nursing Home Licensing Orders
Event ID: VYUH11

Dear Administrator:

The above facility was surveyed on April 19, 2021 through April 22, 2021 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:

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

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

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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 4/19/21-4/22/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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	2 000		

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED H5319047C (MN49743), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5319046C (MN52767), H5319048C (MN70028), H5319049C (MN61592), H5319050C (MN61159), H5319051C (MN61113). 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 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	2 000		

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2 000	Continued From page 2 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 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	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. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living;	2 302		6/4/21

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2 302	Continued From page 3 (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 document review, the facility failed to provide required training on resident Alzheimer's Training / Dementia Training upon hire for 4 of 6 employees (E-1, E-2, E-3, E-4) reviewed for Alzheimer's training. Findings include: Review of employee records revealed the following: E-1 was hired as a nursing assistant on 1/6/21. E-1's Relias transcript indicated E-1 had not completed the Alzheimer's training courses assigned upon hire. E-2 was hired as a nursing assistant on 2/5/21. E-2's Relias transcript indicated E-2 had not completed the Alzheimer's training courses assigned upon hire. E-3 was hired as a registered nurse on 1/13/21. E-3's Relias transcript indicated E-3 had not completed the Alzheimer's training courses	2 302	Corrected	

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2 302	Continued From page 4 assigned upon hire. E-4 was hired as a nursing assistant on 2/5/21. E-4's Relias transcript indicated E-4had not completed the Alzheimer's training courses assigned upon hire. During an interview on 4/20/21, at 1:14 p.m. the Administrator stated employees were informed upon hire of Relias training. The administrator stated he believed dementia training was assigned right away. During a subsequent interview at 3:17 p.m. the administrator stated we do assign dementia training to be completed within the first 30 days of employment. The administrator verified the above findings for E-1, E-2, E-3, E-4. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure all direct care staff and their supervisors receive training on Alzheimer's/dementia care. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that:	2 930		6/4/21

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2 930	Continued From page 5 B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to check placement of gastrostomy tube (G-Tube) for 1 of 1 resident (R18) reviewed for tube feeding who has a history of pulling out the tube. Findings include: R18's Minimum Data Set (MDS) assessment dated 4/19/21 indicated R18 requires extensive assist of one for transfers, dressing, eating and bathing. R18's electronic medical record (EMR) indicated diagnoses of alcohol dependence, metabolic encephalopathy, aphasia, dysphagia, cognitive communication deficit, traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less. R18's progress note dated 4/18/2021 she was found in her room with the G-Tube laying on the blanket next to her. R18 was then sent to the ER where she was admitted as interventional radiology was required to replace tube. R18's dismissal summary indicated R18 has had	2 930	Corrected	

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2 930	Continued From page 6 multiple episodes of pulling the tube out. R18's care plan read to check tube placement for every feeding. During an observation on 4/20/21 at 1:19 p.m. R18 was found chewing on her tube feed tubing. RN-C replaced tube feeding bag and tubing and taped tubing to the side of R18 abdomen. RN-C said R18's has a history of pulling her G-Tube out. RN-C did not check placement prior to setting up new feeding. During an medication administration observation on 4/21/21 at 7:11 a.m. RN-C failed to check placement. During an interview on 4/22/21 at 1:31 p.m., RN-C verified not checking for placement of G-Tube. RN-C stated, "I always check when I flush, but not every time when I do meds, probably should, just did not, little nervous." During interview on 04/22/21 01:54 p.m., Director of Nursing (DON) verified that G-Tube placement should be checked prior to being flushed, administering medications, tube feeding or if R18 had an issue or complaints of abdominal pain. DON verified RN-C received tube feeding education on 4/12/21. Facility Enteral Nutritional Therapy Policy dated June 2017 read check position of tube by placing stethoscope over stomach and instill a small amount of air into Enteral feeding tube. Listen for air to enter stomach. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or	2 930		

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2 930	Continued From page 7 designee could review and revise policies for checking placement according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of checking placement of gastrostomy tubes or other tubes used for nutrition or medication administration prior to those administrations. The DON or designee, should audit placement by all nursing staff assigned to residents effected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 930		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		6/4/21

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21426	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB) risk assessment was completed/updated and 4 of 5 employees (E1, E2, E3, E4,) who did not receive monitoring for TB per Center for Disease Control and Prevention (CDC) guidelines including second step. This had the potential to affect all clients, staff, and visitors entering the facility. Findings include: During Covid the baseline TB blood test or first step of the baseline TST test can be deferred until after the date of hire. Although if the facility have been able to maintain internal new hire screening without deferring the TB test the health care facilities must have documented the date they began modifying their baseline TB screening protocol and all health care facilities must have continued to screen all newly hired HCP for symptoms of TB. According the director of nursing on 4/21/21 this was not completed and said the facility should have completed the testing as they would have prior to Covid. E1 hired 1/5/21, first step was administered from an outside facility 12/30/20, no screening upon hire and no second step completed. E2 hired 2/5/21, first step was given 2/24/21, no second step completed E3 hired 3/16/21, first step given 3/16/21, no	21426	Corrected	

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21426	Continued From page 9 second step given. E4 hired 2/15/21, no screening completed, no first or second step completed. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review current CDC guidelines for tuberculosis control within health care facilities and complete ongoing monitoring of new employees to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan	21535		6/4/21

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21535	Continued From page 10 system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to offer and/or provide non-pharmacological interventions prior to administration of as needed (PRN) pain medications for 2 of 5 residents (R12, R229) reviewed for unnecessary medications. Findings include: R12's face sheet, identified R12 was admitted to the facility on 1/26/21 with diagnoses that included encounter for orthopedic aftercare following surgical amputation of left leg below the knee. R12's admission Minimum Data Set (MDS) assessment dated 2/9/21, identified R12 had moderate cognitive impairment and did not have rejection of care behaviors. The pain assessment portion of the MDS identified R12 had frequent pain that did not interfere with sleep or limit his day-to-day activities, received scheduled pain medication, and PRN pain medication, and had not received non-medication interventions for the pain. The MDS further identified R12 was administered opioid pain medication during the assessment period. R12's care plan dated 2/16/21, included: Pain (Left BKA (below knee amputation) with a hard cast) evidenced by (verbal complaint of phantom pain) r/t (related to): amputation; bilateral inguinal hernia. The interventions included:	21535	Corrected	

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21535	Continued From page 11	21535		

-Will express that pain management is within acceptable limits
-Adjust times of ADL and treatment activities so that occur after analgesic benefits have been achieved (i.e. therapy, wound dressing changes, etc.)
-Administer pain medication per MD orders
- Encourage/Assist to reposition frequently to position of comfort
-Implement non-drug therapies (reposition, watching TV) to assist with pain and monitor for effectiveness.
-Notify MD if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective.
-Report GI distress secondary to analgesia such as nausea, constipation, diarrhea
-Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc.
-Therapy eval and treat as ordered.

R12's medication administration record (MAR) included:
-Oxycodone (opioid pain medication) 5 mg Give 2.5 mg by mouth every 4 hours as needed for increased pain give 2.5 mg 1/2 tab for pain rate of 3-5. Start date 3/12/21.
-Oxycodone (opioid pain medication) 5 mg Give 5 mg by mouth every 4 hours as needed for pain, take whole tablet for pain rate of 6-10. Start date 3/12/21.
-acetaminophen tablet 500 mg, give two tablets by mouth every 6 hours as needed for pain, headache, or fever. Start date 2/4/21.

R12's eAdmin (electronic medication administration) 4/21/2021, at 7:17 p.m. indicated R12 was administered 5 mg of Oxycodone. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
21535	Continued From page 12 record did not specify location or a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. R12's eAdmin (electronic medication administration) 4/21/2021, at 5:30 a.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. R12's eAdmin (electronic medication administration) 4/20/2021, at 7:46 p.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify location or a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated resident request. R12's eAdmin (electronic medication administration) 4/19/2021, at 6:27 p.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify location or a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated resident request. R12's eAdmin (electronic medication administration) 4/18/2021, at 8:46 a.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify what aggravates or alleviates pain and lacked evidence non-pharmacological interventions were attempted or offered. Indicated pain was stabbing at times to left amputation site.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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21535	Continued From page 13 R12's eAdmin (electronic medication administration) 4/16/2021, at 11:47 a.m. indicated R12 was administered 2.5 mg of Oxycodone. For a pain rating of a 6. The record did not specify location or a description, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated ½ tabs given per request. R12's eAdmin (electronic medication administration) 4/15/2021, at 8:16 p.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify location or a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated resident request. R12's eAdmin (electronic medication administration) 4/15/2021, at 8:11 a.m. indicated R12 was administered 2.5 mg of Oxycodone. For a pain rating of a 6. The record did not specify a description of pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated 2 ½ tabs requested for left leg pain. R12's eAdmin (electronic medication administration) 4/13/2021, at 6:51 p.m. indicated R12 was administered 5 mg of Oxycodone. The record did not specify a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated R12 complained of leg/stump pain. R12's eAdmin (electronic medication administration) 4/12/2021, at 6:41 p.m. indicated	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
21535	Continued From page 14 R12 was administered 5 mg of Oxycodone. The record did not specify a description of R12's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. Indicated R12 complained of left leg pain. During an interview on 4/20/21, at 2:51 p.m. registered nurse (RN)-D stated R12 can tell you when he was having pain. When asked to describe the process for administration of PRN pain medications, RN-D described the following process. RN-D would ask R12 to rate his pain, depending on his pain rate RN-D would determine the dose to give. Complete the five rights of medication administration, include time last received to ensure he can receive the medication. Then administer the medication. RN-D stated sometimes point click care [electronic medical system) will direct staff to complete a progress notes for the PRN. RN-D stated progress note would include pain rate and description of pain. RN-D stated try to check back within 1.5 hours and document effectiveness on the MAR. RN-D stated "pain for R12 was worse during the night and R12 was not good about asking for PRN pain medication until it (pain) was really bad and then we will give him 5 mg (oxycodone)". RN-D did not mention offering R12 non-pharmacological interventions prior to administration of a PRN pain medication when she described the process she followed. When questioned specifically about non-pharmacological interventions being offered to R12 for pain, RN-D stated we have done ice and elevate his leg. RN-D stated they did not document non-pharmacological interventions offered or tried and stated we should. RN-D stated, "I can tell you I do not think I have ever	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
21535	Continued From page 15 seen R12 in bed with leg not elevated". During an interview and observation on 4/21/21, at 7:11 a.m. R12 was in his recliner with his legs elevated waiting to leave for an appointment. R12 stated pain was good this morning and described pain as nerve pain in legs when he did have pain. R12 stated they give him two strong pain pills, stated during the day his pain was good and around 7-7:30 p.m. at night was when the pain started and was really painful. R12 stated the staff did not offer non-pharmacological interventions. R12 stated he asked for the pain medications when, "I need it. I have too." R12 stated now she (staff who administers medications) just knows to bring two pain pills at 7:00 p.m. During an interview on 4/21/21, at 1:22 p.m. registered nurse (RN)-C stated usually during the day R12's pain was fine and stated he will ask for pain medication before he goes to bed. RN-C stated R12 had phantom pain, stabbing pain, and will jerk all over. RN-C stated she thought the only thing R12 got relief for the pain was with oxycodone. RN-C stated has not had scheduled oxycodone since he has been here. RN-C stated R12 waits until pain is unbearable almost and then he was wanting the oxycodone. During an interview on 4/22/21, at 9:51 a.m. nursing assistant (NA)-B stated R12's pain management seems better than it was as R12 was having a lot of leg pain when first came. NA-B stated R12 was able to communicate his pain and if R12 said anything about pain we go and tell the nurse right away. NA-B stated she was not told of any non-pharmacological interventions for pain and was not aware of	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
21535	Continued From page 16 anything in particular that they have tried. NA-B stated we do reposition R12 and R12 will let us know when he wants to switch positions. During an interview on 4/22/21, at 8:55 a.m. the director of nursing (DON) stated resident would have to ask or say they are in some kind of pain. The nurse would complete an assessment ask for rate of pain and location of pain and then review PRN orders of what they have available and follow up on the effectiveness. The DON stated staff do offer heat and cold packs, repositioning and any other things that may be listed on the care plans like diversion or activities. The DON stated for R12 non-pharmacological interventions included encourage repositioning for comfort, watching tv, distraction and diversion. The DON stated staff reposition any time they are in there (R12's room). During an interview on 04/22/21, at 9:01 a.m. registered nurse (RN)-A stated it was a standard of care that they (nursing staff) would offer non-pharmacological interventions. RN-A stated she would expect staff to document non-pharmacological interventions with residents with severely impaired cognition. RN-A stated she expected for an alert an orientated resident that request pain medication staff would ask clarifying questions, including would it help to be position in a different way and what precipitated the pain. Once we reviewed those items would provide the pain medications. R229's Minimum Data Set (MDS) assessment dated 4/13/21 indicated cognitive impairment, no behaviors, extensive assistance of 2 staff for activities of daily living, uses walker and wheelchair, occasionally incontinent of bladder,	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
21535	Continued From page 17 continent of bowel, frequent pain, history of falls, and diuretic, anticoagulant, antidepressant use. R229's admission record included diagnoses of unspecified fracture of right femur, difficulty walking, unsteadiness on feet, unspecified abnormalities of gait and mobility, weakness, age related osteoporosis, and chronic kidney disease stage 3. R229's care plan included: pain related to recent surgery with interventions of administer pain medication per physician orders, encourage to reposition frequently to position of comfort, implement non-drug therapies such as watching television, read books and newspaper, and assist with repositioning for pain and monitor for effectiveness. R229's orders included Tylenol 1000 mg three times a day for pain, Tramadol 50 mg every 6 hours as needed for pain rated 6-10. Medication administration record indicated R229 received Tramadol 50 mg as needed on 4/10/21 two times, 4/11/21 two times, 4/13/21 two times, 4/14 two times, 4/15 three times, 4/16 two times, 4/17 once, 4/19 two times, and 4/20 two times. During record review R229's record did not indicate non-pharmacological interventions were offered prior to administering as needed pain medications. During an interview on 4/22/21 at 02:54 p.m., R229 said he gets scheduled Tramadol for pain and is used to taking it as he has taken it for several years for his spine. R229 stated nothing else helps his pain.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
21535	Continued From page 18 During an interview on 4/22/21 at 03:02 p.m., licensed practical nurse (LPN)-A stated R229 has Tramadol as needed. LPN-A stated R229 thinks he is already getting the Tramadol and will ask him if he is having pain. LPN-A stated at night she will offer him an ice pack and he will lay down. LPN-A stated staff do not usually document non-pharmacological interventions offered. During an interview on 4/22/21 at 3:32 p.m., director of nursing (DON) verified Tramadol was ordered as needed. DON stated non-pharmacological interventions are listed in the care plan but not documented prior to administering as needed pain medication. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could evaluate the need foe non-pharmacological interventions used as needed prior to pain medications and monitor compliance with the use of these medications. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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21695	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure 7 of 7 resident rooms (RM 207, 208, 210, 211, 216, 217, 219) were not maintained in a safe, clean and homelike environment. Findings include: During an observation on 4/19/21 at 1:30 p.m., room 210 had a strong urine odor upon entering the room. Tiles were missing underneath bed, food on the chair and floor. Bathroom also had a very strong urine odor, toilet had dried feces on inside of bowl and floor tiles were lifted at the edges and had an uneven surfaces. During an interview and observation on 4/19/21 at 1:50 p.m., room 211 toilet riser and rim of toilet were soiled, dust and hair on toilet rim. Windows were dirty with cobwebs and dead bugs. During an observation on 4/20/21 at 9:50 a.m., room 211 toilet remained dirty and dusty. During interview and observation on 4/21/21 at 12:34 p.m., Maintenance Director (MAINT) - A verified room 209 flooring was missing tiles underneath the bed and tiles in the bathroom were replaced about a year ago and were now lifting at the edges creating an uncleanable surface. During an observation on 4/21/21 at 1:16 p.m., room 211 rim of toilet remains dirty, dusty and windows remained cobwebs and dead bugs in the sills.	21695	Corrected	

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	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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21695	Continued From page 20 During interview and observation on 4/21/21 at 2:40 p.m., administrator verified it was a safety hazard to have floor tiles missing under the bed as well as flooring in the bathroom curling at the edges. Administrator verified the windows were in need of cleaning due to buildup of cobwebs, dust and dead bugs. During an observation on 4/22/21 at 11:14 a.m., rooms 207, 208, 210, 211, 217, 219 had cobwebs and dead bugs in between window panes. Room 210 had a strong urine odor and room 216 had windows that would not close all the way, therefore, 2 cloth napkins were placed in between the window and the frame by resident (R)9. R9 stated maintenance placed the small pieces of foam around the window frame to help close the gap "a long time ago." An ant trap was also observed on the window ledge, no ants seen in room. Based on observation and interview the facility failed to ensure 1 of 1 resident room (Rm. 114) bathroom faucet was kept clean and in a state of good repair. Findings include: On 4/19/21, at 6:34 p.m. room 114 was observed. The bathroom faucet and handles had a thick whitish substance build up. During an interview on 4/22/21, at 10:08 a.m. housekeeper (H)-A stated every day she wiped down and cleaned the faucet and handles but there was so much corrosion we cannot get them clean. H-A stated she used a pumice scouring stick and could not get it clean. H-A stated she reported this concern to maintenance and the	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
21695	Continued From page 21 housekeeping supervisor and was told it was from the hard water and I should keep working on it. During an interview on 04/22/21, at 10:15 a.m. the account manager health care services group (AMHCSG) stated he was aware of the condition of some of the faucets and stated we have really hard water in this building and the Lyme build up was from the hard water. The AMHCSG stated we have talked about replacing faucets. AMHCSG observed the bathroom faucet in room 114 and stated the Lyme build up was not acceptable. During an interview on 4/22/21, at 10:21 a.m. the administrator stated he had not been in the bathroom of room 114 before. The administrator stated if not able to remove the Lyme build up the facility should look at replacing the faucet. The administrator stated he would rely on the maintenance director's recommendation. SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop a regular audit of all resident rooms on a regular basis to ensure timely identification of maintenance issues within the facility. A policy indicating an expectation for a homelike environment and repairs or replacement could be developed by the administrator and/or maintenance director. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21695		
21885	MN St. Statute 144.651 Subd. 21 Patients & Residents Of HC Fac.Bill of Rights	21885		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
21885	Continued From page 22 Subd. 21. Communication privacy. Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. (Only portions indicated of this subdivision are subject to assessment.) This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility who received personal mail, including but not limited to 4 of 4 residents (R1, R2, R3, R11) at the resident council meeting, who verbally confirmed not receiving mail on Saturdays. This has the potential to effect all 23 residents living in the facility. Findings include: On 4/21/21, at 10:00 a.m. a group of residents met to discuss the resident council. When asked whether residents received their mail on Saturdays, all four residents voiced they did not receive their mail on Saturdays. The residents shared the activity director (AC) did not work on Saturdays and the AC was the person who delivered the mail. The residents shared they would get their mail delivered on a Saturday if the AC worked that day.	21885	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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21885	Continued From page 23 During an interview on 4/21/21, at 2:51 p.m. the administrator stated we do have a manager on duty that works the weekends. The administrator stated he expect that mail be delivered six days a week. During an interview on 4/22/21, at 1:12 p.m. the administrator stated it was also his expectation that residents receive mail in a prompt manner. A policy on resident mail was requested and not provided. The Combined Federal and State Bill of Rights revised 6/18/19 included, "The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service." SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure mail was delivered every day mail is delivered by the United States Postal Service. The administrator could educate all appropriate staff. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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21942	Continued From page 24	21942		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council during the past calendar year. Findings include: During an interview on 4/21/21, at 11:12 a.m. the facility social worker (SW) stated the facility did not have an active family council. The SW stated he had posted signs for family council meetings but has not had any family members show up to the meetings. The SW verified the facility had not provided any information to family members regarding formulating a family council, explaining what a family council was or checking to see if the family members would be interested in starting a family council. During an interview on 4/21/21, at 12:52 p.m. the administrator stated he would review the policy	21942	Corrected	6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
21942	Continued From page 25 and procedure for Northshore on what the expectation was for contacting families for family council. A Family Council Policy and Procedure was requested and not provided by the facility. SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document efforts at forming a council and identify when the attempt occurred in the calendar year. TIME PERIOD OF CORRECTION: Twenty-one (21) days	21942		

Electronically delivered
April 16, 2021

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: CCN: 245319
Cycle Start Date: March 24, 2021

Dear Administrator:

Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles.

On March 24, 2021, a survey was completed at your facility by the Minnesota Department of 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)).

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 June 24, 2021 (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 September 24, 2021 (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:

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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
	245319	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/24/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET** **LA CRESCENT, MN 55947**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey La Crescent Health Services 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. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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. IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2021

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 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: fc.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. La Crescent Health Services is a 1-story building with no basement. The building was constructed in 1968 and was determined to be of Type II (000) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 42 beds and had a census of 24 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an unobstructed corridor in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 7.1.10.1 and 19.2.1. This deficient practice could affect all residents within the smoke compartment. Findings include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, observations and staff interview revealed the following: During a tour of the facility, it was observed in the kitchen corridor that one of the smoke barrier doors was obstructed by the placement of a kitchen supply cart.	K 211	K211 Means of egress – General A sign is placed in the kitchen corridor where smoke barrier door was obstructed by placement of a kitchen supply cart. Education will be done with all Kitchen staff on not blocking the smoke barrier doors with objects. Executive Director or designee will monitor for compliance. The date of compliance is 5/24/2021.	5/24/21

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K 211	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 211		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper exit discharge and a transition to grade in accordance with the Life Safety Code NFPA 101 - 2012 edition, section 7.1.6.2. This deficient practice could affect any resident using the exit discharge during an emergency. Findings include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, observations and staff interview revealed the following: During a tour of the facility, it was observed that the transition to grade at the Wing 100 exit door was greater than one inch horizontal and one-half inch vertical. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 271	K271 – Discharge from exits The transition to grade at the Wing 100 exit door will be sealed with concrete calk as needed to ensure the exit door meets code. Maintenance Director or designee will monitor for compliance. The date of compliance is 5/5/2021.	5/24/21

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K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) 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 hazard rooms in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.3.2.1, 19.3.2.1.3, 19.3.2.1.5). This deficient practice could affect all 42 residents.	K 321	K321 – Hazardous areas - Enclosure The combustible storage on Wing 100 is to be properly stored per code in an area that is not open to the corridor. Room 111 will have a storage sign posted on outside of door will have a closer installed. The	5/24/21

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K 321	Continued From page 5 Findings include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, observation revealed the following evidence: 1. There was combustible storage that was open to the corridor in Wing 100; the area was greater than 50 sqft. 2. Resident Room 111 was being used as a storage room without a self-closing door. 3. There was combustible storage within 18 inches of the clothes dryer exhaust duct in the Laundry Room. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 321	combustible material within 18 inches of the clothes dryer exhaust duct was removed and properly stored. The Executive Director, Maintenance director or designee will continue to monitor for compliance. The date of compliance is 5/24/2021.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K 324		5/24/21

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K 324	Continued From page 6 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to verify proper installation of cooking equipment in accordance with the Life Safety Code NFPA 101 - 2012 edition, section 19.3.2.5.3. This deficient practice could affect all residents within the smoke compartment. Findings include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, observation revealed the following evidence: 1. An interlock that would turn off the fuel source to the kitchen gas stove in the event of suppression system activation could not be located. 2. The locked switch for the electric stove located in the Resident Common Area at the end of Wing 100 did not have a timer that would automatically shut off the fuel source to the cooking appliance. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 324	K324 – Cooking facilities La Crescent Health Services has located the interlock on the gas stove in the kitchen that would turn off the fuel source to kitchen gas stove and it is operational. The Electric stove on Wing 100 will have the power cord removed from unit so it is no longer operational. Maintenance Director will monitor for continued compliance. The date of compliance is 5/6/2021.	
K 341 SS=F	Fire Alarm System - Installation	K 341		5/24/21

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K 341	Continued From page 7 CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to maintain the proper installation of the fire alarm system in accordance with the Life Safety Code NFPA 101-2012 edition, section 9.6.1.3, 19.3.4.1 and the National Fire Alarm and Signaling Code NFPA 72-2010 edition, section 29.8.3.4. This deficient practice could affect all 42 residents. Findings include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, observation revealed the following evidence: 1. There was a smoke detector installed within 36" of a direct airflow register in the ceiling of the	K 341	K341 – Fire alarm system - Installation The smoke detector installed within 36” of the direct airflow register will be moved to meet code. Any single station smoke alarms in center will be tested monthly. Maintenance Director will be responsible for the testing of devices. The date of compliance is 5/24/2021.	

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K 341	Continued From page 8 kitchen corridor. 2. There were single-station smoke alarms found at two nurse's stations and one adjacent to Room 202 that had no evidence of being tested monthly. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 341		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install an automatic fire sprinkler system in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 9.7.1.1 and 19.3.5.1, and the Standard for the Installation of Sprinkler Systems NFPA 13 - 2010 edition,	K 351	K351 – Sprinkler system - Installation The closets of rooms 106, 110 and 111 will be modified/disassembled to ensure there is 18” of clearance of the pendant sprinkler deflector. The curtain on Wing 100 Common Area has been replaced by	5/24/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 9 sections 8.5.6.1 and 8.6.5.2.2.1. This deficient practice could affect all residents within the described rooms. Findings include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, observation revealed the following evidence: 1. The sprinkler heads in the closets of Rooms 106, 110, and 111 had shelving with storage within 18 inches of the pendant sprinkler deflector. 2. The sprinkler in Wing 100 Common Area was obstructed by a solid curtain that did not have the approved 18 inches of mesh at the top. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351	a curtain that has the approved 18" of mesh on top to prevent obstruction of sprinkler. Maintenance Director will monitor for compliance. The date of compliance is 5/24/2021.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		5/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/24/2021**

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K 353	Continued From page 10 _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic fire sprinkler system in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 8.5.6.4 and 9.7.5, and the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems NFPA 25 - 2011 edition, sections 5.2.1.4, 5.4.1.4.2, 13.7.1, and 13.7.4. This deficient practice could affect all 42 residents. Findings include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, observation revealed the following evidence: 1. The spare sprinkler storage cabinet did not have enough slots to hold and secure all of the spare sprinklers properly. 2. Holes, gaps, and penetrations were found in the following locations, which could adversely affect the fire sprinkler system's ability to activate: a) There were ceiling tile gaps and openings along the corridor in Wing 100. b) The ceiling tiles had penetrations, openings, and edge gaps in the Kitchen. c) There was a ceiling tile that was propped up for cabling in the BOM Office. d) The ceiling tiles had a gap and penetration in the Equipment Storage Room.	K 353	K353 – Sprinkler System – Maintenance and testing The new spare sprinkler storage cabinet has been installed and sprinkler head storage is now in compliance. The holes, gaps and penetrations will be fixed per code. All ceiling tiles in question will be repaired or replaced. A quarterly maintenance schedule will be in place to be sure all damaged tiles are replaced. Maintenance Director and Executive Director will monitor for compliance. The date of compliance is 5/24/2021.	

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	245319	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/24/2021**

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LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET** **LA CRESCENT, MN 55947**

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K 353	Continued From page 11 e) The ceiling tiles had a gap and penetration in the Central Area Nurse's Station f) The ceiling tiles had a gap and penetration along the Wing 200 corridor. g) The Clean Room at the nurse's station had a missing ceiling tile. 3. The fire department connections on the exterior of the building were obstructed by bread racks. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly mount portable fire extinguishers in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 9.7.4.1 and 19.3.5.12, and the Standard for Portable Fire Extinguishers NFPA 10 - 2010 edition, section 6.1.3.8.3. This deficient practice could affect all 42 residents. Findings include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, it was revealed that a portable	K 355	K355 – Portable fire extinguishers On 3/25/2021, the portable fire extinguisher at the end of the corridor near the exit door of Wing 100 was removed from the building. A fire blanket was then ordered and received by center on 3/31/2021 and is properly stored by Wing 100 exit door per code. Maintenance Director or designee will monitor for compliance. The date of compliance is 5/24/2021.	5/24/21

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K 355	Continued From page 12 water fire extinguisher at the end of the corridor near the exit door of Wing 100 was not correctly mounted. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 355		
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 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 properly seal a wall penetration in accordance with the Life Safety Code NFPA 101 - 2012 edition, section 8.5.6.3. This deficient practice could affect all residents in both smoke compartments. Findings include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, it was observed that there was a penetration in the smoke barrier wall above the	K 372	K372 – Smoke barrier construction The penetration in the smoke barrier wall was repaired to code and will be monitored by Maintenance Director or designee for compliance. The date of compliance is 5/24/2021.	5/24/21

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K 372	Continued From page 13 ceiling, at smoke barrier doors of Wing 200. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper smoke barrier doors in accordance with the Life Safety Code NFPA 101 - 2012 edition, section 8.5.4.1, and the Standard for Fire Doors and Other Opening Protectives NFPA 80 - 2010 edition, section 6.3.1.7.1. This deficient practice could affect all residents in both smoke compartments. Findings Include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, it was revealed that the gap	K 374	K374 – Smoke barrier doors The gap between the leaf edges of the smoke barrier doors for Wing 100 and 200 will be adjusted as needed to ensure doors meet code. Maintenance Director or designee will monitor for compliance. The date of compliance is 5/24/2021.	5/24/21

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K 521	Continued From page 15 discovery.	K 521	of updating the HVAC system would have on La Crescent Health Services. The Maintenance Director or designee will continue to monitor for compliance. The date of compliance is 5/24/2021.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 741	K741 – Smoking regulations	5/24/21

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K 741	Continued From page 16 facility failed to maintain safe smoking practices in accordance with the Life Safety Code NFPA 101 - 2012 edition, section 19.7.4. This deficient practice could affect any staff using the staff smoking area. Findings Include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, it was revealed that there was a disassembled cigarette butt receptacle in the staff smoking area outside the rear of the building. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 741	The disassembled cigarette butt receptacle in the staff smoking area is now reassembled in rear of the building on 4/17/2021. Executive Director or designee will monitor for compliance. The date of compliance is 5/24/2021.	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, section 6.3.2.1 and the National Electrical Code NFPA 70 - 2011 edition, section 314.25. This deficient practice could affect all residents in the kitchen and dining room. Findings Include:	K 911	K911 – Electrical Systems - Other The junction box above the ceiling in the kitchen that was attached to the air handler that did not have a junction box cover now has a cover placed per code. Maintenance Director or designee will monitor for compliance. The date of compliance is 5/24/2021.	5/24/21

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K 911	Continued From page 17 On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, it was revealed that there was a junction box above the ceiling in the kitchen that was attached to the air handler that did not have a junction box cover. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 911		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords 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. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced	K 920		5/24/21

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K 920	Continued From page 18 by: Based on observation and staff interview, the facility failed to prohibit the unsafe use of power-taps in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, section 10.2.3.6 and the National Electrical Code NFPA 70 - 2011 edition, section 400.8. This deficient practice could affect all residents within the smoke compartment. Findings Include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, it was revealed that there was a multiplug power tap in the Laundry Room that extends through the ceiling to an unknown location. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	K920 – Electrical equipment – Power cords and extension cords The multiplug power tap in the laundry room that extended through the ceiling to an unknown source was removed. Maintenance Director or designee will monitor for compliance. The date of compliance is 5/24/2021.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet 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	K 923		5/24/21

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K 923	Continued From page 19 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet 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 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." 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. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to separate medical gas cylinders in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, section 11.6.5.2. This deficient practice could affect all 42 residents. Findings Include: On facility tour between 10:30 AM and 04:30 PM on 03/24/2021, it was revealed that there was no segregation or full and empty cylinders in the Med Gas Storage Room. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 923	K923 – Gas Equipment – Cylinder and container storage On 4/17/2021, all cylinders were placed in a corresponding full and empty location, so they are segregated, and all cylinders have appropriate tags. Executive Director or designee will monitor for compliance. The date of compliance is 5/24/2021.	

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K 923	Continued From page 20 discovery.	K 923		

Electronically delivered
May 24, 2021

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: CCN: 245319
Cycle Start Date: March 24, 2021

Dear Administrator:

On April 16, 2021, we informed you that we may impose enforcement remedies.

Compliance with the Life Safety Code (LSC) deficiencies cited on March 24, 2021 has not yet been verified.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 24, 2021. (42 CFR 488.417 (b))

The CMS Region V Office will notify your Medicare Adminstrative Contractor (MAC) that the denial of payment for new admissions is effective June 24, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 24, 2021. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, La Crescent Health Services is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 24, 2021. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us