

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 28, 2021

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

RE: CCN: 245569 Cycle Start Date: January 12, 2021

Dear Administrator:

On January 12, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

#### 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.

Halstad Living Center January 28, 2021 Page 2

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), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900 Email: <u>susan.frericks@state.mn.us</u> Mobile: (218) 368-4467

## 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

Halstad Living Center January 28, 2021 Page 3

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 April 12, 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 July 12, 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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.

Halstad Living Center January 28, 2021 Page 4 Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 28, 2021

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

#### Re: State Nursing Home Licensing Orders Event ID: FGSF11

Dear Administrator:

The above facility was surveyed on January 12, 2021 through January 12, 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 <u>only a suggestion</u> 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>. 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.

Halstad Living Center January 28, 2021 Page 2

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:

Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900 Email: <u>susan.frericks@state.mn.us</u> Mobile: (218) 368-4467

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Delivered Electronically

March 1, 2021

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

Subject: Halstad Living Center – Administrative review 2567 modification CMS Certification Number (CCN): # 245569 Event ID: FGSF11

Dear Administrator:

This is a notice of an administrative review of a citation cited at tag F600 issued pursuant to the survey Event ID FGSF11, completed on January 12, 2021 as a part of MDH's Quality Assurance review. As a result of this review, it was determined the deficiency cited did not represent an immediate jeopardy situation, and confirmed you had already implemented corrective action to remove the deficient practice prior to our onsite survey.

Since we have determined this is not a valid example of a current deficient practice under this regulation, it will be removed from the Statement of Deficiencies.

A revised Statement of Deficiencies is attached.

Sincerely,

usan B. France

Susan Frericks, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 218-368-4467

cc: Office of Ombudsman for Long-Term Care Brenda Fischer, Assistant Program Manager Licensing and Certification File

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00764	B. WING		C 01/12/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HALSTA	D LIVING CENTER		RTH AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	conducted to detern Licensure. Your fac compliance with the indicate in your elec you have reviewed date when they will	reviated survey was nine compliance with State ility was found to be NOT in MN State Licensure. Please ctronic plan of correction that these orders, and identify the				
ABORATOR	epartment of Health 7 DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 01/29/21

Electronically Signed

STATE FORM

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If continuation sheet 1 of 6

Minneso	ta Department of He	alth			FURI	APPROVE
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2 000	Continued From pa	ge 1	2 000			
		laint was found to be H5569010C (MN#68962) with sued at S#1995				
		ed in ePOC and therefore a uired at the bottom of the first				
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			2/11/21
	(a) Each facility sho ongoing written pro applicable licensing of suspected maltre facility has an interr mandated reporter requirements of this internally. However	I reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains aplying with the immediate eats of this section.				
	by: Based on interview facility failed to ens to resident abuse w the administrator ar two hours, reported	ent is not met as evidenced and document review, the ure an alleged violation of staff vas immediately reported to nd immediately, no later than to the State Agency (SA) for 1 reviewed for allegations of		Corrected.		
	Findings include:					
	11/17/20, identified	imum Data Set (MDS) dated R1 had severe cognitive d diagnoses which consisted				

Minnesota Department of Health STATE FORM

FGSF11

If continuation sheet 2 of 6

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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21995	of dementia, a hip f The MDS indicated assistance with mo (ADL's) which inclu dressing, toileting a MDS identified R1 of limited assistance w R1's care plan revi was at risk for injury status with a goal of and neglect every of R1 required extens ADL's which include toileting, personal h plan indicated R1 h processes and corr dementia and instru- meet R1's needs. The facility's inciden 1/9/21, at 10:45 p.n resident quit being was reported to the 20 hours and 25 mi occurred. Review of the facilith handwritten notes r p.m. the director of report from staff req resident verbal abu The DON spoke to 1/10/21, who was w confirmed LPN-A to The DON spoke to also working on 1/9 told R1, "quit being	racture and Diabetes Mellitus. R1 required extensive st activities of daily living ded bed mobility, transfers, nd personal hygiene. The did not walk and required	21995				

Minnesota Department of Health STATE FORM

FGSF11

If continuation sheet 3 of 6

				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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21995	Continued From page	ge 3	21995			
	NA-A verified she w she, NA-B and LPN station at around 10 his wheelchair whee station. NA-A confir language and LPN- asshole". NA-A confir abuse and should n confirmed she did n anyone until the new reported it to the ch day. NA-A confirme requirement to repo since LPN-A was he felt too intimidated t	9 p.m. during an interview, orked on 1/9/21. NA-A stated -A were seated at the nurses 0:45 p.m. when R1 who was in eled himself up to the nurses med R1 had used foul A stated to R1, "quit being an firmed it was a form of verbal ot have happened at all. NA-A ot report the verbal abuse to at day on 1/10/21, when she arge nurse sometime that d she was aware of the rt it immediately and stated er charge nurse on 1/9/21, she o report it immediately.	A			
NA-B sta 6:00 a.m were se p.m. wh foul lang not reca LPN-A s NA-B co abuse ir reported aware a	NA-B stated she wo 6:00 a.m. NA-B con were seated at the r p.m. when R1 whee foul language when not recall exactly wh LPN-A stated to R1 NA-B confirmed this NA-B confirmed she abuse immediately reported it immediately	p.m. during an interview, orked 1/9/21, from 6:00 pm. to firmed she, NA-A and LPN-A nurses station around 10:45 eled up to the desk and used he was talking. NA-B could nat R1 said. NA-B confirmed , "quit being an asshole". was a form of verbal abuse. e did not report the verbal and believed NA-A had tely. NA-B confirmed she was s of abuse were expected to ately.				
	licensed social work a phone call from th 6:00 p.m. and asked a VA report due to a	p.m. during an interview, ker (LSW) stated she received le DON on 1/10/21, at around d her to go to the facility to file in allegation of verbal abuse. s informed by the DON on				

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00764		CONSTRUCTION	COM	E SURVEY PLETED C 12/2021
						12/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S <sup>-</sup> J <b>RTH AVENUE</b>			
HALSTA	D LIVING CENTER		D, MN 56548	EAST		
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21995	and emotional abus condoned. LSW co abuse occurred on not reported to the The LSW stated all be reported immedi On 1/12/21, at 2:10 the DON, she state charge nurse worki an allegation of veri 1/9/21, at 10:45 p.n NA-A and NA-B on LPN-A stated to R1 confirmed it was a fistated the facility has stated the facility has stated it was expect never occur at the fibelieved the facility the abuse did not re psychosocial harm. policy, DON confirm reported the allegation occur and the facility did re	confirmed it was verbal, menta se and stated it should not be nfirmed the allegation of 1/9/21, at 10:45 p.m. and was SA until 1/10/21, at 7:10 p.m. allegations of abuse were to iately. p.m. during an interview with d she was called by the ng on 1/10/21, at 2:33 p.m. of bal abuse that occurred on n. DON stated she spoke with 1/10/21, and both confirmed , "quit being an asshole". DON form of verbal abuse and ad no tolerance for it. DON ted any form of abuse should facility. DON stated she had 24 hours to report it since				
	the administrator sh allegations of abuse Administrator confir	p.m. during an interview with he stated she expected all be reported immediately. med she was informed of the 21, at around 2:30 p.m. and				

FGSF11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ (°СОМ	E SURVEY PLETED
		00764	B. WING			C 12/2021
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
IALSTA	D LIVING CENTER		RTH AVENUE 0, MN 56548	EAST		
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21995	stated they provide about the expectati abuse immediately allegation occurred the allegation of ve timely as required. Review of the facilit Mistreatment and N Property revised 5/ were to reported pe policy stated the fac violations of abuse immediately but no allegation was mad SUGGESTED MET The director of nurs review and revise p reporting incident o nursing or designed educate staff and d ensure medication DON, administrator assurance committ measures to ensure	d education to NA-A and NA-B on to report all allegations of or within two hours after the . The administrator confirmed rbal abuse was not reported ty policy titled Abuse, Neglect, <i>A</i> isappropriation of resident 17, indicated abuse allegations er federal and state law. The cility would ensure all alleged were to be reported t later than two hours after the le. THOD OF CORRECTION: sing (DON) or designee could policies and procedures for if abuse. The director of e could develop a system to levelop a monitoring system to were correctly reported to the r and State Agency. The quality the could monitor these	21995			

FGSF11

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>ОМВ NO</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /		PLE CONSTRUCTION		TE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER	I	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTAI	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
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F 000	INITIAL COMMENT	rs	FC	000	)		
	completed at your f investigation. Your f compliance with 42 for Long Term Care						
	The following comp substantiated: H5569010C.	laint was found to be					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 600 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Free from Abuse ar		F 6	600	)		2/11/21
	Exploitation The resident has th neglect, misapprop and exploitation as includes but is not I corporal punishmen any physical or che	rom Abuse, Neglect, and ne right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to medical symptoms.					
	§483.12(a) The fac	ility must-					
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE 01/29/2021

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.

PRINTED: 02/04/2021

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/04/2021 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	LTIPLE CONSTRUCTION DING	COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
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F 600	Continued From pa	ge 1	F	600		
	<ul> <li>physical abuse, cor involuntary seclusic This REQUIREMEN by:</li> <li>Based on interview facility failed to prov of 3 residents (R1) incident of employed occurred.</li> <li>Findings include:</li> <li>R1's admission Mir 11/17/20, identified impairment and have of dementia, a hip f The MDS indicated assistance with mo (ADL's) which includ dressing, toileting a MDS identified R1 of limited assistance w</li> <li>R1's care plan revis was at risk for injury status with a goal of and neglect every of R1 required extens ADL's which include toileting, personal h plan indicated R1 h processes and corr dementia and instru- meet R1's needs.</li> </ul>	NT is not met as evidenced y and document review, the yide freedom from abuse for 1 reviewed for abuse when an e to resident verbal abuse mum Data Set (MDS) dated R1 had severe cognitive d diagnoses which consisted racture and Diabetes Mellitus. R1 required extensive st activities of daily living ded bed mobility, transfers, and personal hygiene. The did not walk and required		It is the policy of Halstad Liv that all residents have the rig from abuse, neglect, misapp resident property, and exploi Halstad Living Center must r verbal, mental, sexual, or phy corporal punishment or invol seclusion. Based on interview document review, Halstad Lir failed to provide freedom from of 3 residents for abuse whe of employee to resident verb occurred. LPN-A was immed suspended upon notification verbal and emotional abuse a terminated upon completion investigation. NA-A and NA-E provided immediate disciplina and education regarding time reporting of verbal and emoti During interview with NA-A a DON/ADMIN asked if they has witnessed/observed any othe types of abuse from LPN-A to residents. NA's state this was only resident they had witness of abuse to. No other reports made regarding abuse to oth All staff will finish completing Mandated Reporting and Vul & Abuse & Neglect Preventio review and testing by Februa and complete further Mandat	yht to be free ropriation of tation. not use ysical abuse, untary w and ving Center m abuse for 1 n an incident al abuse liately of alleged and later of B were ary action ely mandated ional abuse. nd NA-B, ad er/similar o other s the first and ssed this type s have been her residents annual herable Adult on Policy ary 5th, 2021	

Facility ID: 00764

If continuation sheet Page 2 of 10

	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPL F			0938-039
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(	2
		245569	B. WING			01/1	2/2021
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER				3 FOURTH AVENUE EAST ALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 600	Continued From pa	age 2	F 60	00			
	"asshole". The facility internal notes indicated on director of nursing of staff regarding alleg verbal abuse which spoke to nursing as who was working of the LPN-A told R1, indicated she believ changed over the p had been more neg spoke to NA-B on 1 LPN-A stated to R1 asshole". DON con to the start of LPN- was suspended un resident verbal abu Review of the faciliti 1/12/21, LPN-A was related to the follow not keeping resider offensive behavior/ multiple employees efficiently and in ha negative behavior a and staff and incon	investigation handwritten 1/10/21, at 2:33 p.m. the (DON) received a report from gations of staff to resident occurred on 1/9/21. The DON ssistant (NA)-A on 1/10/21, n 1/9/21, and she confirmed "quit being an asshole". NA-A ved the LPN-A's attitude had bast month and stated LPN-A gative towards staff. The DON 1/10/21, and she confirmed on 1/9/21, "quit being an tacted LPN-A on 1/10/21, prior A's shift and informed her she til an investigation regarding use was completed. ty termination letter dated s terminated effective 1/12/21, ving: verbal abuse to resident, nts safe or free of abuse, discrimination towards s, not performing tasks urmony with other employees, about and towards residents siderate, rude, impolite, or vulgar treatment or			and Vulnerable Adult & Abuse & Ne Prevention education by February 7 2021. Visual audits will be complete DON or Designee and will review a Agency reported abuse allegations ensure the facility reported the alleg in a timely manner for 1 month, the audits/month for 2 months, then me thereafter until 100% compliance is attained and maintained. Visual au- then be completed randomly by DO Designee on all reported abuse allegations thereafter to ensure cor compliance. In addition, the DON/Designee will conduct observ and interviews of staff/residents reg care practices 3 times per month for months, then monthly thereafter to that any concern of abuse has bee reported timely and investigations conducted thoroughly, until 100% compliance is attained and maintai Audits will be reported to the Qualit Assurance Committee and QAPI Committee quarterly and as neede Quality Assurance Committee will r	11th, ed by Il State to gation n 3 onthly dits will DN or ntinued ation garding or 2 ensure n ned. y d. The nake	
	On 1/12/21, at 12:5 NA-A verified she w she, NA-B and LPN station at around 10 his wheelchair whe	f residents and employees. 9 p.m. during an interview, vorked on 1/9/21. NA-A stated V-A were seated at the nurses 0:45 p.m. when R1 who was in eled himself up to the nurses rmed R1 had used foul					

If continuation sheet Page 3 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/04/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245569	B. WING	i			C 12/2021
NAME OF I	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 600	language and LPN- asshole". NA-A con abuse and should r stated she had notic LPN-A's attitude an LPN-A's job was to him like that. NA-A and he deserved to respect. On 1/12/21, at 1:11 NA-B stated she wo 6:00 a.m. NA-B cor were seated at the p.m. when R1 whee foul language when not recall exactly wi LPN-A stated to R1 NA-B confirmed this NA-B stated LPN-A recently and staff he her attitude. On 1/12/21, at 2:00 licensed social worl a phone call from th 6:00 p.m. and aske a VA report due to a LSW stated she wa 1/9/21, at 10:45 p.m being an asshole". mental and emotior not be condoned. On 1/12/21, at 2:10 the DON, she state charge nurse worki an allegation of vertice.	ge 3 A stated to R1, "quit being an firmed it was a form of verbal not have happened at all. NA-A ced a recent change in d behavior and stated care for R1 and not to treat stated this was R1's home be treated with dignity and p.m. during an interview, orked 1/9/21, from 6:00 pm. to offirmed she, NA-A and LPN-A nurses station around 10:45 eled up to the desk and used he was talking. NA-B could hat R1 said. NA-B confirmed , "quit being an asshole". s was a form of verbal abuse. had become more negative ad noticed a recent change in p.m. during an interview, ker (LSW) stated she received he DON on 1/10/21, at around d her to go to the facility to file an allegation of verbal abuse. Is informed by the DON on h. that LPN-A told R1, "quit LSW confirmed it was verbal, hal abuse and stated it should p.m. during an interview with d she was called by the ng on 1/10/21, at 2:33 p.m. of bal abuse that occurred on h. DON stated she spoke with	F	600			

If continuation sheet Page 4 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 02/04/20 FORM APPROV OMB NO. 0938-03		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED	
		245569	B. WING				C 12/2021	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
HALSTA	D LIVING CENTER				133 FOURTH AVENUE EAST HALSTAD, MN 56548			
(X4) ID PREFIX TAG	MENT OF DEFICIENCIES AN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE         245569       245569         COF PROVIDER OR SUPPLIER         STAD LIVING CENTER         ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO         600         Continued From page 4         NA-A and NA-B on 1/10/21, and both confir LPN-A stated to R1, "quit being an asshole NA-A informed DON she had noticed a rec change in AP's behavior and attitude. DON she contacted LPN-A on 1/10/21, prior to th of her shift and informed her she was susp pending further investigation. DON stated s and the administrator met with LPN-A at 11 a.m. on 1/12/21, and terminated LPN-A at t time. DON confirmed it was a form of verba abuse and stated the facility had no toleran it. DON stated it was expected any form of should never occur at the facility.         On 1/12/21, at 3:03 p.m. during an interview the administrator she stated she expected a allegations of abuse be reported immediate Administrator stated she was informed of th allegation on 1/10/21, at around 2:30 p.m. a she went to the facility to assist with investif further. The administrator stated she and th DON spoke with NA-A and NA-B on 1/10/2 discuss further and confirmed it was a form verbal abuse towards R1. The administrator stated the DON called LPN-A and suspend on 1/10/21, prior to her next shift pending th investigation. The administrator stated she the DON met with LPN-A on 1/12/21, and terminated LPN-A at that time due to the ve abuse that occurred and confirmed it was	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	NA-A and NA-B on LPN-A stated to R1 NA-A informed DOI change in AP's beh she contacted LPN of her shift and info pending further inve and the administrat a.m. on 1/12/21, an time. DON confirme abuse and stated th it. DON stated it wa should never occur On 1/12/21, at 3:03 the administrator stated allegations of abuse Administrator stated allegation on 1/10/2 she went to the faci further. The admini- DON spoke with NA discuss further and verbal abuse toward stated the DON call on 1/10/21, prior to investigation. The a the DON met with L terminated LPN-A a abuse that occurred expected all resider occurring in the faci Review of facility po Mistreatment and M Property revised 5/ the use of oral, writt willfully inflicts dispa	1/10/21, and both confirmed , "quit being an asshole". N she had noticed a recent avior and attitude. DON stated -A on 1/10/21, prior to the start rmed her she was suspended estigation. DON stated she or met with LPN-A at 11:00 d terminated LPN-A at that ed it was a form of verbal he facility had no tolerance for s expected any form of abuse at the facility. p.m. during an interview with he stated she expected all e be reported immediately. d she was informed of the 21, at around 2:30 p.m. and lity to assist with investigating strator stated she and the A-A and NA-B on 1/10/21, to confirmed it was a form of ds R1. The administrator led LPN-A and suspended her her next shift pending the dministrator stated she and .PN-A on 1/12/21, and it that time due to the verbal d and confirmed it was hts were free from any abuse	F	500				

	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TID	LE CONSTRUCTION	MB NO. 0938 (X3) DATE SUR	
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETE	
					С	
		245569	B. WING		01/12/20	21
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HALSTA	D LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COME	(X5) PLETIO DATE
F 600	Continued From pa	ge 5	F 600			
	each resident would be free from abuse in the facility and indicated abuse included verbal, mental, sexual, or physical abuse. Reporting of Alleged Violations					
		d Violations	F 609		2/11/	/21
		onse to allegations of abuse, n, or mistreatment, the facility				
	involving abuse, ne mistreatment, inclu- source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cau abuse and do not re the administrator of officials (including t adult protective ser for jurisdiction in lor accordance with St procedures.	re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established				
	designated represe accordance with St Survey Agency, with incident, and if the	ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken.				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIEN/CLA       (X2) MULTIPLE CONSTRUCTION         AND PLAN OF CORRECTION       245569       B. WING         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         HALSTAD LIVING CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D         F 609       Continued From page 6 to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.       F 609         F 1ndings include:       R1's admission Minimum Data Set (MDS) dated 11/1/7/20, identified R1 had severe cognitive impairment and had diagnoses which consisted of dementia, a hip fracture and Diabetes Mellitus. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion.       Previde they had witnessed/observed any other/s types of abuse from LPN-A to o residents. NA's state this was ti negative with NA-A and DON/ADMIN asked if they had witnessed/observed any other/s types of abuse from LPN-A to o residents. NA's state this was ti only resident they had witnesse of abuse to. No other reports ha	FORM. OMB NO.	0938-039		
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2IP CODE         HALSTAD LIVING CENTER       133 FOURTH AVENUE EAST         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST GE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PROVIDER'S PLAN OF CORREC (EACH DEFICIENCY MUST GE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PROVIDER'S PLAN OF CORREC (EACH DEFICIENCY MUST GE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PROVIDER'S PLAN OF CORREC (EACH DEFICIENCY)         F 609       Continued From page 6 to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.       F 609       Involving, abuse, neglect, exploit mistreatment are reported imme but not later than 2 hours after tallegation involve abuse result is serious injury; or not lat hours if the events that cause the allegation do not involve abuse assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion.       The administrator of the Halstad Livi and later terminated upon comp investigation. NA-A and NA-B w provided immediate disciplinary and education regarding timely reporting of verbal and emotional and later terminated upon comp investigation. NA-A and NA-B w provided immediate disciplinary and education regarding timely reporting of verbal and emotion.         R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from	· · ·	(X3) DATE SURVEY COMPLETED C 01/12/2021		
HALSTAD LIVING CENTER       133 FOURTH AVENUE EAST HALSTAD, MN 56543         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)         F 609       Continued From page 6 to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.       F 609         Findings include:       Findings include:         R1's admission Minimum Data Set (MDS) dated 11/17/20, identified R1 had severe cognitive impairment and had diagnoses which consisted of dementia, a hip fracture and Diabetes Mellitus. The MDS indicated R1 required extensive assistance with locomotion.       F 609         R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with locomotion.       The MDS indicated bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 tid no twalk and required limited assistance with locomotion.       DON/ADMIN asked if they had witnessed/observed any other/s types of abuse from LPN-A to o residents. NA's state this was th they had witnesse of abuse to. No other reports ha				
HALSTAD LIVING CENTER       HALSTAD, MN 56548         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SMO CROSS-REFERENCE TO THE APP DEFICIENCY)         F 609       Continued From page 6 to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.       F 609         F Indings include:       F1's admission Minimum Data Set (MDS) dated 11/17/20, identified R1 had severe cognitive impairment and had diagnoses which consisted of dementia, a hip fracture and Diabetes Mellius. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion.       F 100 FREFIX TAG         R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers,       DN/ADMIN asked if they had witnessed/observed any other/s types of abuse from LPN-At oo orly resident they had witnesse of abuse to. No other reports ha				
PREFX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFX TAG(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)F 609Continued From page 6 to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.F 609involving, abuse, neglect, explo mistreatment are reported imme but not later than 2 hours after t allegation involve abuse.F1/15 admission Minimum Data Set (MDS) dated 11/117/20, identified R1 had severe cognitive impairment and had diagnoses which consisted of dementia, a hip fracture and Diabetes Mellitus. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion.Involving, abuse, neglect, explo mistreatment are reported imme but not later than 2 hours after t allegation do not involve abuse result is serious bodily injury, to administrator of the Halstad Livi and later terminated upon comp investigation. NA-A and NA-B w provided immediate disciplinary and education regarding timely reporting of verbal and emotional and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers, ADL's which included bed mobility, transfers,PREFIX TAGF 1000F 1000F 1000F 1000F 1100F 1000F 1000F 1100F 1000F 1000F 11000F 1000F 1000 <td< td=""><td></td><td colspan="3"></td></td<>				
<ul> <li>to resident abuse was immediately reported to the administrator and immediately, no later than two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.</li> <li>Findings include:</li> <li>R1's admission Minimum Data Set (MDS) dated 11/1/7/20, identified R1 had severe cognitive impairment and had diagnoses which consisted of dementia, a hip fracture and Diabetes Mellitus. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion.</li> <li>R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers, AD</li></ul>	ULD BE	(X5) COMPLETIO DATE		
<ul> <li>two hours, reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse.</li> <li>Findings include:</li> <li>R1's admission Minimum Data Set (MDS) dated 11/17/20, identified R1 had severe cognitive impairment and had diagnoses which consisted of dementia, a hip fracture and Diabetes Mellitus. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion.</li> <li>R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers, dDL's which included bed mobility, transfers, dDL's</li></ul>				
Findings include:hours if the events that cause the allegation do not involve abuseR1's admission Minimum Data Set (MDS) datedallegation do not involve abuseR1's admission Minimum Data Set (MDS) datedallegation do not involve abuse11/17/20, identified R1 had severe cognitiveadministrator of the Halstad Liviimpairment and had diagnoses which consistedad other officials LPN-A wasof dementia, a hip fracture and Diabetes Mellitus.immediately suspended upon mediately suspended upon m	he that ise or			
<ul> <li>impairment and had diagnoses which consisted of dementia, a hip fracture and Diabetes Mellitus. The MDS indicated R1 required extensive assistance with most activities of daily living (ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion.</li> <li>R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers,</li> </ul>	nat and do not o the			
<ul> <li>(ADL's) which included bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R1 did not walk and required limited assistance with locomotion.</li> <li>R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers,</li> <li>investigation. NA-A and NA-B with provided immediate disciplinary and education regarding timely reporting of verbal and emotion. During interview with NA-A and DON/ADMIN asked if they had witnessed/observed any other/s types of abuse from LPN-A to o residents. NA's state this was thread only resident they had witnessed of abuse to. No other reports have of abuse to. No other reports have of abuse to. No other reports have on the provided immediate disciplinary and education regarding timely reporting of verbal and emotion.</li> </ul>	otification			
R1's care plan revised 12/27/20, identified R1 was at risk for injury due to vulnerable adult (VA) status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers,	ere action mandated			
status with a goal of R1 to be free from abuse and neglect every day. The care plan identified R1 required extensive assistance with most ADL's which included bed mobility, transfers,types of abuse from LPN-A to o residents. NA's state this was th only resident they had witnesse of abuse to. No other reports had	NA-B,			
	ther le first and d this type			
toileting, personal hygiene and dressing. The care plan indicated R1 had an alteration in thoughtmade regarding abuse to other All staff will finish completing an Mandated Reporting and Vulnerprocesses and communication problem due toMandated Reporting and Vulner	residents. nual			
dementia and instructed staff to anticipate and meet R1's needs. & Abuse & Neglect Prevention F review and testing by February and complete further Mandated	Policy 5th, 2021 Reporting			
The facility's incident report indicated that on 1/9/21, at 10:45 p.m. staff stated LPN-A said to a resident quit being an "asshole". The allegation was reported to the SA on 1/10/21, at 7:10 p.m.and Vulnerable Adult & Abuse 8 Prevention education by Februa 2021. Visual audits will be comp DON or Designee and will revie	ry 11th, leted by			
20 hours and 25 minutes after the incident occurred.Agency reported abuse allegationReview of the facility internal investigationaudits/month for 2 months, there	ons to allegation then 3			

Facility ID: 00764

If continuation sheet Page 7 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/04/2021 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245569	B. WING				C 12/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HALSTAD LIVING CENTER			133 FOURTH AVENUE EAST HALSTAD, MN 56548					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 609	handwritten notes re p.m. the director of report from staff reg resident verbal abus The DON spoke to 1/10/21, who was w confirmed LPN-A to The DON spoke to also working on 1/9 told R1, "quit being notified the adminis the investigation. On 1/12/21, at 12:5 NA-A verified she w she, NA-B and LPN station at around 10 his wheelchair whee station. NA-A confir language and LPN- asshole". NA-A confir language and LPN- asshole". NA-A confir language and LPN- asshole". NA-A confir language and should m confirmed she did m anyone until the new reported it to the ch day. NA-A confirme requirement to repor since LPN-A was he felt too intimidated to On 1/12/21, at 1:11 NA-B stated she wo 6:00 a.m. NA-B com were seated at the p p.m. when R1 whee foul language when not recall exactly wi LPN-A stated to R1	ge 7 evealed on 1/10/21, at 2:33 nursing (DON) received a garding allegations of staff to se which occurred on 1/9/21. nursing assistant (NA)-A on vorking on 1/9/21, and she ld R1, "quit being an asshole". NA-B on 1/10/21, who was /21, and she confirmed LPN-A an asshole". The DON trator immediately and started 9 p.m. during an interview, vorked on 1/9/21. NA-A stated -A were seated at the nurses 0:45 p.m. when R1 who was in eled himself up to the nurses med R1 had used foul A stated to R1, "quit being an firmed it was a form of verbal to thave happened at all. NA-A not report the verbal abuse to kt day on 1/10/21, when she arge nurse sometime that d she was aware of the ort it immediately and stated er charge nurse on 1/9/21, she to report it immediately. p.m. during an interview, orked 1/9/21, from 6:00 pm. to firmed she, NA-A and LPN-A nurses station around 10:45 eled up to the desk and used he was talking. NA-B could hat R1 said. NA-B confirmed , "quit being an asshole".	F	609	thereafter until 100% compliance is attained and maintained. Visual aut then be completed randomly by DC Designee on all reported abuse allegations thereafter to ensure cor compliance. In addition, the DON/Designee will conduct observ and interviews of staff/residents reg care practices 3 times per month for months, then monthly thereafter to that any concern of abuse has bee reported timely and investigations conducted thoroughly, until 100% compliance is attained and maintai Audits will be reported to the Qualit Assurance Committee and QAPI Committee quarterly and as needed Quality Assurance Committee will r recommendations for ongoing mon	dits will DN or ntinued ation garding or 2 ensure n ned. y d. The nake		

If continuation sheet Page 8 of 10

		AND HUMAN SERVICES				FORM	02/04/2021 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		245569	B. WING	i			C 12/2021
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
	D LIVING CENTER				133 FOURTH AVENUE EAST		
TIALSTA	D LIVING CLATER				HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Continued From pa	ge 8	Fe	609	9		
	abuse immediately reported it immedia aware all allegation be reported immedi On 1/12/21, at 2:00	e did not report the verbal and believed NA-A had tely. NA-B confirmed she was s of abuse were expected to ately. p.m. during an interview, ker (LSW) stated she received					
	a phone call from th 6:00 p.m. and aske a VA report due to a LSW stated she wa 1/9/21, at 10:45 p.m an asshole". LSW co and emotional abus condoned. LSW co abuse occurred on not reported to the	the DON on 1/10/21, at around d her to go to the facility to file an allegation of verbal abuse. Is informed by the DON on the LPN-A told R1, "quit being confirmed it was verbal, mental are and stated it should not be infirmed the allegation of 1/9/21, at 10:45 p.m. and was SA until 1/10/21, at 7:10 p.m. allegations of abuse were to					
	the DON, she state charge nurse working an allegation of veril 1/9/21, at 10:45 p.m NA-A and NA-B on LPN-A stated to R1 confirmed it was a fist stated the facility has stated it was expect never occur at the fist believed the facility the abuse did not re- psychosocial harm. policy, DON confirm reported the allegate hours after the incide	p.m. during an interview with d she was called by the ng on 1/10/21, at 2:33 p.m. of bal abuse that occurred on n. DON stated she spoke with 1/10/21, and both confirmed , "quit being an asshole". DON form of verbal abuse and ad no tolerance for it. DON ted any form of abuse should acility. DON stated she had 24 hours to report it since esult in physical or After review of the facility ned the facility should have ion immediately or within two dent occurred. DON confirmed tred on 1/9/21, at 10:45 p.m.					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 02/04/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	CON	E SURVEY NPLETED
		245569	B. WING	i			/12/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
HALSTAD LIVING CENTER					33 FOURTH AVENUE EAST HALSTAD, MN 56548		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609	and the facility did r 1/10/21, at 7:10 p.m after the incident of On 1/12/21, at 7:10 p.m after the incident of On 1/12/21, at 3:03 the administrator sh allegations of abuse Administrator confir allegation on 1/10/2 she went to the faci further. The administrator confir DON spoke with NA discuss further and verbal abuse toward stated they provided about the expectation abuse immediately allegation occurred the allegation of ver- timely as required. Review of the facilitt Mistreatment and M Property revised 5/7 were to reported per policy stated the face violations of abuse	p.m. during an interview with the stated she expected all the stated she expected all the be reported immediately. The stated she was informed of the the stated she was informed of the the at around 2:30 p.m. and lity to assist with investigating strator stated she and the A-A and NA-B on 1/10/21, to confirmed it was a form of ds R1. The administrator d education to NA-A and NA-B on to report all allegations of or within two hours after the . The administrator confirmed the abuse was not reported the abuse allegations of r federal and state law. The cility would ensure all alleged were to be reported alater than two hours after the	F	609			

If continuation sheet Page 10 of 10