

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245569	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Halstad Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 133 Fourth Avenue East Halstad, MN 56548	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observation, interview, and document review, the facility failed to ensure three years of survey results were readily accessible for residents or visitors. This deficient practice had the potential to affect all 43 residents currently residing in the facility and any visitors.</p> <p>Findings include:</p> <p>During an observation on 6/2/25 at 12:23 p.m., the facility survey results were located in a binder which was placed in a plastic bin attached to the wall across from the dining room approximately four feet from the ground. The last survey results noted in the folder were from a recertification survey dated 8/23/23.</p> <p>In review of survey results from 11/22 to 6/2/25, the binder lacked the following survey results:</p> <ul style="list-style-type: none"> -11/15/22, an abbreviated survey was completed. -12/22/22, an abbreviated survey was completed. -9/21/23, an abbreviated survey was completed. -4/17/24, a recertification survey was completed. <p>During an interview on 6/2/25 at 1:40 p.m., administrator confirmed survey results prior to and after 8/23/23, were not included in the binder and were not readily accessible for the residents or visitors to review. Administrator stated her expectation was the folder would have been kept up to date with all surveys.</p> <p>A policy on posting survey results was requested however, one was not provided.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and editable data, during 1 of 1 quarters reviewed (Quarter 1), October 1-December 31st 2024, to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This deficient practice had the potential to affect all 43 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705 D for quarter 1 identified excessively low weekend staffing, one star staffing rating, no RN hours for every day in quarter 1 and failed to have licensed nursing coverage 24 Hours/Day for every day in quarter 1. Review of staff timecards from the first quarter verified the facility did not have excessively low weekend staffing. Further identified, the facility had RN coverage for at least 8 hrs per day and the facility had licensed nursing coverage 24 Hours/Day.</p> <p>During an interview on 6/3/25 at 10:33 a.m., administrator verified she was the one that submitted PBJ reports for the facility and she was unaware the facility was triggering for the areas listed above on the PBJ report. Administrator stated on 12/2/24, the director of nursing (DON) hours were submitted as 26.25 hours and anytime staff hours were submitted for over 24 hours in a day, all the staff hours for that whole quarter were rejected. Administrator further stated it was a clerical error that caused all of the PBJ data to be rejected for the quarter. Administrator stated her expectation was that all PBJ data would have been submitted accurately to reflect the correct amount of staffing for the facility.</p> <p>Review of a facility policy titled Payroll Based Journal revised 10/24, identified it was the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. Further identified the administrator was responsible for reviewing validation reports and ensuring that any needed corrections were made before the quarterly deadline.</p>		