DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2025

Administrator
Mahnomen Health Center

414 WEST JEFFERSON AVENUE
MAHNOMEN, MN 56557

Re: Reinspection Results
Event ID: 0OMW11

Dear Administrator:

On July 10, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 4, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 16, 2025

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: June 4, 2025

Dear Administrator:

On June 4, 2025, 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 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 September 4, 2025 (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 December 4, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 16, 2025

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

Re: State Nursing Home Licensing Orders
Event ID: 0OMW11

Dear Administrator:

The above facility was surveyed on June 2, 2025 through June 4, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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
	245238	A. BUILDING _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE MAHNOMEN, MN 56557

(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 6/2/25 through 6/4/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/2/25 through 6/4/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)	F 604		6/26/25

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

Electronically Signed | 06/20/2025

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

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F 604	Continued From page 1 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free from physical restraints while in bed for 2 of 2 residents (R8, R17) reviewed for restraints. Findings include:	F 604	Correction for Tag F604: Free of restraints/use of pool noodles. 6-4-25: Impromptu IDT meeting was held with core staff as well as med nurses and NARs to discuss the use of pool noodles on residents R8 and R17. After this meeting, it was determined that the pool	

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F 604	Continued From page 2 R8: R8's quarterly Minimum Data Set (MDS) dated 5/21/25, identified R8 had a mild cognitive impairment and had diagnoses that included history of a stroke, hallucinations, disorientation, restlessness and agitation, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness). R8 was nonambulatory and required touching/supervision assistance for eating and was dependent on staff for all other care areas. The MDS identified no restraints were used for R8. R8's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 2/20/25, identified R9 was dependent on staff for most ADLs and R8 had left sided neglect from a stroke. R8's care plan revised 5/22/25, identified R8, on admit, did seem to be a low risk for falls/elopement. R8 was chair fast and could not move herself to transfer and could not walk. R8 required a full body mechanical lift for all transfers, but did move a little in bed at night. Staff were directed to place a pool noodle on the edge of R8's bed to prevent falls. R8's medical record failed to identify a restraint assessment for the use of the pool noodle. During an observation on 6/3/25 at 9:52 a.m., nursing assistant (NA)-A and NA-B assisted R8 to lie down in bed. NA-A and NA-B provided incontinence care for R8 and positioned R8 on her left side to be able to take a nap. At 10:00 a.m., NA-A covered R8 with a blanket then placed a pool noodle (a long foam cylinder approximately	F 604	noodles were not needed and they were removed at that time. 6-4-25: Education to all staff informing them that pool noodles were considered a restraint if placed under the fitted sheet and the resident could not remove themselves. 6-12-25: R8 and R17 residents were reassessed for removal of the pool noodles. It was concluded that they did not need them at this time. Restraint statues 483.12 will be reviewed at the next staff meeting as well as QAPI with the core staff, both on June 26th. Falls meeting will also be held on June 26th. There we will discuss the use of pool noodles as a fall intervention. Pool noodles will be avoided as a fall intervention, due to the risk of being a restraint. Therapy and nursing rehab will be updated at this meeting as well. Moving forward: Any fall interventions that could possibly be considered a restraint will be avoided, other interventions will be attempted. If at any time a fall intervention may be considered a restraint, nursing will follow the 483.12 statues on restraints and develop a policy. 6/24/25: At the impromptu meeting on 6/4/25, all other residents were also audited to ensure that the use of pool noodles were not in place. Pool noodles were not used on any other resident. 6/24/25: DON will continue to educate staff and supportive staff that the use of pool noodles is not appropriate due to the risk for being a restraint. Education will	

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F 604	Continued From page 3 5 feet in length and 3 inches in diameter) behind R8 underneath R8's fitted sheet. NA-A lowered R8's bed to the floor and exited R8's room. During an interview on 6/3/25 at 10:02 a.m., NA-A stated a pool noodle was put under the fitted sheet in case R8 rolled over so R8 couldn't fall on the floor. During an observation on 6/4/25 at 9:10 a.m., NA-D and NA-E assisted R8 to lie down in bed. - At 9:19 a.m., NA-D placed the pool noodle under R8's fitted sheet and lowered R8's bed to the floor. During an interview on 6/4/25 at 9:27 a.m., NA-D stated, when R8 was first admitted, R8 would throw her legs out of bed and try to get up. Staff put the pool noodle under the fitted sheet to prevent R8 from doing that. NA-D stated R8 had never been seen trying to remove the pool noodle but R8 had left sided weakness and probably couldn't remove the pool noodle. During an interview on 6/4/25 at 10:08 a.m., registered nurse (RN)-A stated, when R8 was first admitted, R8 would throw her legs over the side of the bed to get out of bed. The pool noodle prevented R8 from doing that. RN-A stated R8 was unable to remove the pool noodle. RN-A's eyes widened then stated, "that's a restraint." R17: R17's quarterly Minimum Data Set (MDS) dated 2/26/25, identified severe cognitive impairment. R17 was dependent with bed mobility and transfers. The MDS identified restraints were not used with R17.	F 604	occur monthly at the staff meeting as well as Communication log for the next 3 months. Monthly visual audit will be completed by DON to ensure that there are no pool noodles or other potential restraints used as fall interventions. Visual monthly audits will continue through the next calendar year. This data will be shared at the QAPI meeting, to ensure that staff know the importance of restraints.	

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F 604	Continued From page 4 R17's medical record failed to identify a restraint assessment for the use of the pool noodle. During observation on 6/4/25 at 8:40 a.m., trained medication assistant/nursing assistant (TMA)-A and TMA-B put R17 to bed. Once in bed TMA-A placed a pool noodle under the fitted sheet along R17's left side. During an interview on 6/4/25 at 8:49 p.m., TMA-A stated R17 was not mobile but moved her legs around and toward the edge of the bed and was at risk to fall. R17 was a fall risk, and the pool noodle kept R17 in bed and R17 was not able to get over the pool noodle. During an interiew on 6/4/25 at 10:19 a.m., the director of nursing (DON) stated the pool noodle was a fall intervention. The DON stated she nor the staff considered the pool noodle could be a possible restraint and had not completed a restraint assessment. Residents should have been assessed to determine if there was an alternative option and/or how to use the restraint as safely as possible. A restraint policy was requested but not received.	F 604		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 641	Correction for Tag 641: Accuracy of the	6/27/25

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F 641	Continued From page 5 facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 2 residents (R11, R27) reviewed for unnecessary medications; 2 of 2 residents (R8, R17) reviewed for restraints; and 7 of 7 residents (R4, R8, R26, R6, R10, R17, R20, R26) reviewed for grab bars. Findings include: MEDICATIONS: R11 R11's annual Minimum data set (MDS) dated 3/26/25, identified R11 had a moderate cognitive impairment and had diagnoses that included dementia, major depressive disorder, anxiety, and chronic obstructive pulmonary disease (COPD). R11used antipsychotic, antianxiety, and antidepressant medications. The MDS further identified R11 had not had a gradual dose reduction (GDR) or R11 had documented an indication for use. R11's physician orders identified the following: - buspirone (antianxiety medication) 7.5 milligram (mg) tablet; take 1 tablet by mouth three times a day. - donepezil ((cholinesterase inhibitors) Donepezil is a medication primarily used to treat dementia associated with Alzheimer's disease. It helps improve cognitive functions such as attention, memory, and daily activities in patients with dementia. Donepezil is indicated for mild to severe dementia and may result in a small benefit in mental function.) Take 1 tablet at bedtime. - Lexapro (escitalopram oxalate) (antidepressant) 10 mg tablet; take 1 tablet by mouth daily. - mirtazapine (antidepressant) 15 mg tablet; take	F 641	MDS 6-4-25: Education with the MDS coordinator was done, specifically for; GDR requirements for antipsychotic medications, Medications taken, specifically anticoagulants (Aspirin is not considered an anticoagulant), restraints and bed rails claimed. Reviewed that the use of pool noodles were considered a restraint and the use of grab bars should be claimed as bed rails. Education to MDS coordinator the importance of correct data on the MDS, encouraged her to check and double check her data before signing off. 6-4-25: MDS coordinator is new to her position and soon a brand new RN grad. MDS manual is downloaded on her computer for easy reference. MDS coordinator is taking an in person MDS training in August 2025 in Bismarck. RAC-CT cert. This will expand her knowledge in the MDS. Education to core staff at next QAPI meeting for those who are completing the MDS assessments and the importance of claiming correct data. Next QAPI meeting is June 26th. DON will review the MDS, specifically in these areas and others that may need correcting before they are completed. Real time education will be done with staff if any errors are found. DON submits all the MDS. DON will add MDS accuracy to QAPI and will monitor all the competed MDS through QAPI. DON will reassess next	

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F 641	Continued From page 6 ½ tablet (7.5 mg) by mouth daily at bedtime. R11's physician orders failed to identify R11 used an antipsychotropic medication. R11's Pharmacy Monthly Medication Review dated 12/19/24, identified R11's medication regimen review was complete. No pharmacy recommendations at this visit. Dose of Remeron recently reduced due to daytime drowsiness and decreased appetite. R11 appeared to be tolerating dose reduction thus far and continued to be followed closely by psychiatry. R11 Psychiatry Provider Note dated 3/6/25, identified the following: R11's Psychiatric Problem History: Alzheimer's Dementia R11 presented with a history of memory impairment, moderate to severe in intensity, with additional impairments in executive functioning, learning, language, social cognition, as well as having visual perception problems, impacting the patient in all contexts of life and requiring structured living with nursing support. R11 met criteria for a DSM diagnosis of Major Neurocognitive disorder/dementia, most likely of Alzheimer's type. Major Depressive Disorder R11 presented with an endorsement of depression symptoms occurring most days, moderate in intensity, affecting R11 in a number of contexts both at home and at work or when away from home. Symptoms included low mood, sadness, feelings of hopelessness, low energy, problems with concentration, appetite and sleep disturbance, and at times R11 would have feelings of low self-worth. The periods of depression were episodic, lasting two weeks or more, meeting the DSM criteria for Major	F 641	quarter for continued need and further education. Unnecessary meds: R11 MDS dated 3/26/25 will be corrected by 6/27/25 for GDR of an Antipsychotropic medications. GDR documentation will be corrected to show that the resident has had a DGR recently Remeron and that this was clinically indicated by the provider. R27’s MDS dated 3/11/25 will be modified by 6/27/25 with corrections to “unnecessary meds” under medication section. Removal of anticoagulants that was previously checked. Pool Noodles/Bed Rails: R8’s MDS dated 5/21/25 will be modified by 6/27/25 with corrections to Restraints. The use of pool noodles was in place and this needs to document as a restraint on the mds. Also the use of a Restraint will be added to this MDS due to the use of Grab bars/bed rails. R17’s MDS dated 2/26/25 will be modified by 6/27/25 with corrections to Restraints. The use of pool noodles was in place and this needs to documented as a restraint on the MDS. Also the use of a restraint will be added to this MDS due to the use of Grab bars/bed rails. R4’s MDS dated 3/19/25 will be modified 6/27/25 with corrections to restraints due to the use of grab bars/bed rails.	

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F 641	Continued From page 7 Depression, recurrent. Generalized Anxiety Disorder (GAD) R11 presented with a recent history of ongoing daily anxiety symptoms with ruminative worry, tight muscles, initial insomnia, and autonomic arousal, occurring in a number of contexts, and meeting DSM criteria for GAD. Continue Buspar (buspirone)7.5 mg three times a day for Anxiety Lexapro 10 mg daily for MOD/anxiety Remeron (mirtazapine)7.5mg daily at bedtime for MDD/GAD - decreased 12/17/2024 Aricept (donepezil) 10mg daily at HS for dementia During an interview on 6/3/25 at 3:55 p.m., the director of nursing (DON) stated R11's MDS was incorrectly coded as R11 taking an antipsychotropic medication, R11 had GDR of Remeron, and her medications were clinically indicated by the psychiatrist. The MDS is important for payment reimbursement and to ensure GDR and documentation was correct. "It must have been missed." R27: R27's admission MDS dated 3/11/25, identified R27 had diabetes mellitus and was receiving and anticoagulant (blood thinner). R27's physician order's dated 3/6/25, did not indicate R27 was on an anticoagulant. During an interview on 6/4/25 at 12/20 p.m., the DON stated when the resident was admitted they were not taking an anticoagulant and the admission MDS was coded in error and should have been reviewed.	F 641	R26's MDS dated 4/30/25 will be modified by 6/27/25 with corrections to restraints due to the use of grab bars/bed rails. R6's MDS dated 3/19/25 will be modified by 6/27/25 with corrections to restraints due to the use of grab bars/bed rails. R10's MDS dated 3/19/25 will be modified by 6/27/25 with corrections to restraints due to the use of grab bars/bed rails. R20 MDS dated 3/5/25 will be modified by 6/27/25 with corrections to restraints due to the use of grab bars/bed rails. 6/24/25: By 6-20-25 all residents that have current Grab bars in place; assessment were completed and consents done. All the remaining residents who have grab bars in place but were not cited on the state survey tag, their MDS will be modified and resubmitted with the Grab bars/bed rails added to their MDS by 6/27/25. 6/24/25: MDS accuracy will be added to weekly IDT on Mondays and Thursdays. Review of the current MDS will be done at this time as an added check for accuracy on the MDS. This will give the MDS coordinator and DON the time to discuss any concerns or questions that the MDS coordinator may have. Nursing will focus on the areas of concern with unnecessary meds, GDR and proper documentation, Restraints, and any other areas of concerns that arise. DON will also review	

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F 641	Continued From page 8 RESTRAINTS: R8 R8's quarterly MDS dated 5/21/25, identified R8 had a mild cognitive impairment and had diagnoses that included history of a stroke, hallucinations, disorientation, restlessness and agitation, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness). R8 was nonambulatory and required touching/supervision assistance for eating and was dependent on staff for all other care areas. The MDS further identified no restraints were used for R8. R8's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 2/20/25, identified R9 was dependent on staff for most ADLs and R8 had left sided neglect from a stroke. The MDS failed to identify R8 used a restraint. R8's care plan revised 5/22/25, identified R8, on admit, did seem to be a low risk for falls/elopement. R8 was chair fast and could not move herself to transfer and could not walk. R8 required a full body mechanical lift for all transfers, but did move a little in bed at night. Staff were directed to place a pool noodle on the edge of R8's bed to prevent falls. During an observation on 6/3/25 at 9:52 a.m., nursing assistant (NA)-A and NA-B assisted R8 to lie down in bed. NA-A and NA-B provided incontinence care for R8 and positioned R8 on her left side to be able to take a nap. At 10:00 a.m., NA-A covered R8 with a blanket then placed a pool noodle (a long foam cylinder approximately	F 641	the MDS after the MDS coordinator has completed and before the MDS is due. DON submits all the MDS, as this will prevent any MDS that may be missed for a 2nd check. MDS review will be added to IDT agenda indefinitely and QAPI measure for the next calendar year and will be reassessed at that time for continued monitoring. 6/24/25: Yearly refresh training will be completed by DON to continue to be current on any changes/updates to MDS.	

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F 641	Continued From page 9 5 feet in length and 3 inches in diameter) behind R8 underneath R8's fitted sheet. NA-A lowered R8's bed to the floor and exited R8's room. During an interview on 6/3/25 at 10:02 a.m., NA-A stated a pool noodle was put under the fitted sheet in case R8 rolled over so R8 couldn't fall on the floor. During an observation on 6/4/25 at 9:10 a.m., NA-D and NA-E assisted R8 to lie down in bed. - At 9:19 a.m., NA-D placed the pool noodle under R8's fitted sheet and lowered R8's bed to the floor. During an interview on 6/4/25 at 9:27 a.m., NA-D stated, when R8 was first admitted, R8 would throw her legs out of bed and try to get up. Staff put the pool noodle under the fitted sheet to prevent R8 from doing that. NA-D stated R8 had never been seen trying to remove the pool noodle but R8 had left sided weakness and probably couldn't remove the pool noodle. During an interview on 6/4/25 at 10:08 a.m., registered nurse (RN)-A stated, when R8 was first admitted, R8 would throw her legs over the side of the bed to get out of bed. The pool noodle prevented R8 from doing that. RN-A stated R8 was unable to remove the pool noodle. RN-A's eyes widened then stated, "that's a restraint." R17: R17's quarterly MDS dated 2/26/25, identified R17 had severe cognitive impairment and was dependent on staff for bed mobility and transfers. The MDS identified R17 was not using restraints.	F 641		

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F 641	Continued From page 10 R27's Restraints and Alarms assessment dated 2/26/25, identified resident R27 did not use restraints or alarms, and did not identfiy the use of a pool noodle R27's care plan dated 5/14/25, did not identify the use of restraints. During observation on 6/4/25 at 8:40 a.m., trained medication assistants (TMA)-A and TMA-B assisted resident to bed following breakfast. When R27 was in bed TMA-A placed a 3 inch high pool noodle under the fitted sheet on the left side of the bed. R27 was seen to have a long, raised area under the fitted sheet on the right side of the bed. R27 had side rails up on each side of the bed. During an interview on 6/4/25 at 8:50 a.m., TMA-A stated the pool noodles were used to keep R27 in her bed, R27 cannot get out of bed when the pool noodles were in place. During an interiew on 6/4/25 at 10:19 a.m., the director of nursing (DON) stated the pool noodles were for a a fall intervention. The DON stated she nor the staff considered the pool noodle could be a possible restraint and was not coded on the MDS as a restraint. GRAB BARS/ BEDRAILS R4 R4's annual MDS dated 3/19/25, identified R4 had a severe cognitive impairment and had diagnoses that included dementia. R4 was nonambulatory, required substantial assistance	F 641		

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F 641	Continued From page 11 for eating and was dependent on staff for all other care areas. The MDS did not identify R4 used grab bars. During an observation on 6/4/25 at 8:51 a.m., R4 did not use his bilateral bedrails to assist with turning nor did NA-C or NA-D encourage him to do so. R8 R8's quarterly MDS dated 5/21/25, identified R8 had a mild cognitive impairment and had diagnoses that included history of a stroke, hallucinations, disorientation, restlessness and agitation, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness). R8 was nonambulatory and required touching/supervision assistance for eating and was dependent on staff for all other care areas. The MDS further identified no restraints were used for R8. R8's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential CAA dated 2/20/25, identified R9 was dependent on staff for most ADLs and R8 had left sided neglect from a stroke. The MDS failed to identify R8 used grab bars. R8's care plan revised 5/22/25, identified R8, on admit, did seem to be a low risk for falls/elopement. R8 was chair fast and could not move herself to transfer and could not walk. R8 required a full body mechanical lift for all transfers, but did move a little in bed at night. The care plan failed to identify R8 used grab bars. During an observation on 6/3/25 at 9:52 a.m.,	F 641		

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F 641	Continued From page 12 NA-A and NA-B assisted R8 to lie down in bed. NA-A and NA-B provided incontinence care for R8 and positioned R8 on her left side to be able to take a nap. R8 did not use her grab bars to assist with turning and repositioning nor did NA-D or NA-E encourage her to do so. During an observation on 6/4/25 at 9:10 a.m., NA-D and NA-E assisted R8 to lie down in bed. R8 did not use her grab bars to assist with turning and repositioning nor did NA-D or NA-E encourage her to do so. During an interview on 6/4/25 at 9:27 a.m., NA-D stated R8 was unable to use her grab bars and staff completed turning for R8. R26 R26's quarterly MDS dated 4/30/25, identified R26 had a severe cognitive impairment and diagnoses that included epilepsy, generalized anxiety disorder, history of craniotomy (A craniotomy is a surgical procedure that involves removing part of the bone from the skull to expose the brain. The section of bone removed is called the bone flap, which is temporarily removed and then replaced after the brain surgery has been done. If the bone flap is not replaced, it is either a craniectomy (bone removed) or cranioplasty (non-osseous surgical repair). R26 required supervision/touching assistance with personal hygiene, and partial/moderate assistance with toileting. The MDS did not identify R26 used grab bars. During an observation on 6/4/25 at 7:16 a.m., R26 was lying in bed, curled up in ball, with her face sticking out of the blankets. R26 was	F 641		

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F 641	Continued From page 13 sleeping. A grab bar was connected to R26 bed on each side. During an observation on 6/4/25 at 1:03 p.m., R26's bed had grab bars on each side. R6: R6's quarterly MDS dated 3/19/25, identified no cognitive impairment and identified R6 had not used bed rails/grab bars or restraints. R6's care plan dated 5/16/25, identified R6 used the grab bars on both sides of the bed to turn and reposition. During observation on 6/4/25 at 9:56 a.m., R6's bed was observed to have grab bars on both sides of the bed. R10: R10's annual MDS dated 3/19/25, identified moderate cognitive impairment and diagnosis of a stroke. The MDS did not identify the use of bed rails/grab bars. R10's care plan dated 6/2/25, identified R10 used grab bars to reposition in bed. During observation on 6/4/25 at 1:17 p.m., R10's bed was observed to have grab bars on both sides of the bed. R20: R20's quarterly MDS dated 3/5/25, identified no cognitive impairment and a diagnosis of	F 641		

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F 641	Continued From page 14 Parkinson's disease (a progressive neurological disorder which affects movement, causing symptoms like tremors, stiffness, and slow movement). The MDS did not identify use of bed rails/grab bars. During observation on 6/4/25 at 9:56 a.m., R20's bed was observed to have grab rails on both sides of the bed. During an interview on 6/4/25 at 10:19 a.m., the DON stated the grab bars should have been coded on the MDS and were not. A facility policy related to MDS accuracy was requested but not received.	F 641		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700		6/26/25

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F 700	Continued From page 15 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents with attached grab bars were comprehensively assessed for use on the bed for 7 of 7 residents (R4, R8, R26, R6, R10, R17, R20) whom had grab bars. Findings include: R4 R4's annual Minimum Data Set (MDS) dated 3/19/25, identified R4 had a severe cognitive impairment and had diagnoses that included dementia. R4 was nonambulatory, required substantial assistance for eating and was dependent on staff for all other care areas. The MDS did not identify R4 used grab bars. R4's care plan dated 7/7/22, identified R4 was contracted at bilateral knees to 90 degrees flexion (bent). R4 had pain with some stretching into extension more in left knee than in right knee but was able to complete range of motion (ROM) at ankles and hips with no difficulties. Res. also has tightness noted in left ring and pinky finger, no other tightness or difficulties noted with ROM in bilateral upper extremities. The care plan did not identify R4 used grab bars for bed mobility. R4's medical record failed to identify a grab bar assessment to include entrapment risk, risk versus benefits, consent, bed dimentions in	F 700	Correction for Tag F700: Bed Rails 6-4-25: Impromptu IDT held with core staff, med nurses and NARs and PT in regards to continued need for grab bars for residents R8 and R4. DON completed an Adaptive equipment/restraint assessment on both R8 and R4 residents. Conclusion from the assessment and the IDT; both grab bars could be removed as they may no longer be necessary. The Grab bars were removed from R8 and R4 beds. 6-4-25: Impromptu IDT also discussed the remaining residents who had grab bars and the continued need for them. List was developed, reviewed/brainstormed. Staff concluded that these residents did benefit from the grab bars, but will be assessed as well for continued need, risk and benefits explained, consent given and provider order obtained. 6-4-25: Maintenance staff was informed of the concerns brought by the state surveyors. Maintenance staff did assess each grab bar for correct placement, measurements and any other concerns for entrapment. All the grab bars were well within the measurement requirements of statue 483.25 All remaining residents that are using grab	

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F 700	Continued From page 16 relation to the residents height and weight and what alternatives were attempted or containdicated before installation. During an observation on 6/4/25 at 8:51 a.m., nursing assistant (NA)-C and NA-D assisted R4 to lie down in bed and incontinence cares. At 8:55 a.m., R4 was transferred into bed with a full body mechanical lift. R4 sat upright in the sling with his hands and arms resting across his chest and lap. NA-C and NA-D rolled R4 from left to right to pull R4's pants and performed incontinence cares. R4 did not use his bilateral grab bars to assist with turning nor did NA-C or NA-D encourage him to do so. At 8:57 a.m., R4 stated his face was up against the right-side grab bar and NA-C apologized to R4 and assisted him to roll towards the left slightly to allow room for R4's face. During an interview on 6/4/25 at 9:09 a.m., NA-C and NA-D stated R4 was unable to move on his own and staff needed to "move" R4 for him. R4 never used his grab bars and R4 was unable to help at all with turning; staff had to turn R4. NA-D stated R4 was too stiff and contracted to be able to use his grab bars. During an interview on 6/4/25 at 10:01 a.m., registered nurse (RN)-A was not aware why R4 had grab bars. R4 couldn't roll/turn on his own and staff had to assist him completely. RN-A stated R4's grab bars needed to be assessed to ensure he even needed them. R8 R8's quarterly MDS dated 5/21/25, identified R8 had a mild cognitive impairment and had	F 700	bars will have an adaptive/restraint use assessment completed as well as consent assessment completed by 6/20/25. This assessment/consent contains; how many grab bars needed, why it is needed and what limitations/DX do the resident have to warrant the grab bars. Risks and benefits will be explained to resident and or representatives about the need for the grab bars and the safety concerns that go along with grab bars. Care plans will all be updated by 6/20/25. Education to families will be sent out informing them of the correction tag and what correction is as well. Again, risk and benefits will be discussed. Families will also be made aware that this consent for continued use of grab bars will be discussed at care conferences and PRN. Education will be sent out by 6/20/25. Education to all staff will be done at next staff meeting and QAPI meeting to discuss the importance of proper assessments for grab bars, risk and benefits of using and the importance of removing them when no longer needed. Education will be done June 26th. Going forward: All new admitted residents will be assessed per therapy while they complete their initial EVAL. Grab bar placement was added to therapies communication forms and will be used for new admits and PRN use. Nursing will complete the Adaptive equipment/restraints assessment along with the Consent observation. Care plan will be developed.	

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F 700	Continued From page 17 diagnoses that included history of a stroke, hallucinations, disorientation, restlessness and agitation, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness). R8 was nonambulatory and required touching/supervision assistance for eating and was dependent on staff for all other care areas. The MDS did not identify R8 used grab bars. R8's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 2/20/25, identified R9 was dependent on staff for most ADLs and R8 had left sided neglect from a stroke. The CAA did not identify R8 used grab bars. R8's care plan revised 5/22/25, identified R8, on admit, did seem to be a low risk for falls/elopement. R8 was chair fast and could not move herself to transfer and could not walk. R8 required a full body mechanical lift for all transfers, but did move a little in bed at night. Staff were directed to place a pool noodle on the edge of R8's bed to prevent falls. The care plan did not identify R8 used grab bars. R8's medical record failed to identify a grab bar assessment to include entrapment risk, risk versus benefits, consent, bed dimentions in relation to the residents height and weight and what alternatives were attempted or containdicated before installation. During an observation on 6/3/25 at 9:52 a.m., nursing assistant (NA)-A and NA-B assisted R8 to lie down in bed. NA-A and NA-B provided incontinence care for R8 and positioned R8 on her left side to be able to take a nap. R8 did not use her grab bars to assist with turning and	F 700	If nursing thinks that a grab bar is needed for a current resident, a provider order for a therapy consult will be done and therapy will assess the need for the grab bars. Nursing will complete the grab bar assessment with therapy recommendations and consent along with education with resident and or families. Care plan will be updated. Grab bar assessments will be completed every quarter or PRN, added to care conference sheet for consent from resident and or families explaining the risks and benefits. Assessment will also be used to determine if the grab bars remain necessary. Grab bars will be claimed on the MDS as a Bed rail. QAPI measure will be added for proper placement and assessment completed for all new grab bars placed. Maintenance will audit proper placement, measurements and any safety concerns they find. Audits will be done monthly and data provided to DON to review at the QAPI meetings. Grab bar policy was updated. 6/24/25: Grab bar placement will be added to the monthly Fall meeting mins as a regular topic, under the safety concerns. Nursing will review all residents who have grab bars, the reasoning and the continued need for them. Grab bars will remain on the meeting agenda indefinitely. This will initiate PRN assessments along with regular quarterly assessments to ensure that the need for	

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	245238	A. BUILDING _____ B. WING _____	06/04/2025

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F 700	Continued From page 18 repositioning nor did NA-D or NA-E encourage her to do so. During an observation on 6/4/25 at 9:10 a.m., NA-D and NA-E assisted R8 to lie down in bed. R8 did not use her grab bars to assist with turning and repositioning nor did NA-D or NA-E encourage her to do so. During an interview on 6/4/25 at 9:27 a.m., NA-D stated R8 was unable to use her grab bars and staff completed turning for R8. R26 R26's quarterly MDS dated 4/30/25, identified R26 had a severe cognitive impairment and diagnoses that included epilepsy, generalized anxiety disorder, history of craniotomy (A craniotomy is a surgical procedure that involves removing part of the bone from the skull to expose the brain. The section of bone removed is called the bone flap, which is temporarily removed and then replaced after the brain surgery has been done. If the bone flap is not replaced, it is either a craniectomy (bone removed) or cranioplasty (non-osseous surgical repair). R26 required supervision/touching assistance with personal hygiene, and partial/moderate assistance with toileting. The MDS failed to identify R26 used grab bars. R26's care plan did not identify R26 used grab bars. R26's PT Evaluation & Plan of Treatment dated 8/1/24, did not identify R26's need for grab bars.	F 700	grab bars is still relevant for that resident. This data will be transferred to the QAPI plan.	

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F 700	Continued From page 19 R26's medical record failed to identify a grab bar assessment to include entrapment risk, risk versus benefits, consent, bed dimentions in relation to the residents height and weight and what alternatives were attempted or containdicated before installation. During an observation on 6/4/25 at 7:16 a.m., R26 was lying in bed, curled up in ball, with her face sticking out of the blankets. R26 was sleeping. A grab bar was connected to R26 bed on each side. During an observation on 6/4/25 at 1:03 p.m., R26's bed had grab bars on each side. A black canvas material cover with pockets was over each grab bar and held R26's personal items. Licensed practical nurse (LPN)-A stated R26 used the grab bars to help roll in bed and transfer herself. When a resident was admitted to the facility, staff put in a request for maintenance to put the grab bars on the bed, if the resident needed them. LPN-A believed physical therapy made that decision. During an interview on 6/4/25 at 1:08 p.m., LPN-A stated she asked and was told grab bars were addressed during an IDT meeting after the resident was admitted but ultimately nursing was responsible for the assessment. During an interview on 6/4/25 at 1:10 p.m., RN-A stated usually when a resident was admitted they just come with siderails. RN-A "thought" it was part of the physical therapy evaluation, but it was something staff needed to work on. RN-A stated staff didn't realize a grab bar could be a potential problem.	F 700		

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F 700	Continued From page 20 R6: R6's quarterly MDS dated 3/19/25, identified no cognitive impairment and identified R6 had not used bed rails/grab bars or restraints. R6's care plan dated 5/16/25, identified R6 used the grab bars on both sides of the bed to turn and reposition. R6's medical record failed to identify a grab bar assessment to include entrapment risk, risk versus benefits, consent, bed dimentions in relation to the residents height and weight and what alternatives were attempted or containdicated before installation. During observation on 6/4/25 at 9:56 a.m., R6's bed was observed to have grab bars on both sides of the bed. R10: R10's annual MDS dated 3/19/25, identified moderate cognitive impairment and diagnosis of a stroke. The MDS did not identify the use of bed rails/grab bars. R10 medical record failed to identify a grab bar assessment to include entrapment risk, risk versus benefits, consent, bed dimentions in relation to the residents height and weight and what alternatives were attempted or containdicated before installation. During observation on 6/4/25 at 1:17 p.m., R10's bed was observed to have grab bars on both sides of the bed.	F 700		

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F 700	Continued From page 21 R17: R17's quarterly MDS dated 2/26/25, identified R17 had severe cognitive impairment and was dependent on staff for bed mobility and transfers. The MDS identified resident was not using restraints. R17's Restraints and Alarms assessment dated 2/26/25, identified resident R27 did not use restraints or alarms. The assessment did not identify the grab bars. R17's medical record failed to identify a grab bar assessment to include entrapment risk, risk versus benefits, consent, bed dimentions in relation to the residents height and weight and what alternatives were attempted or containdicated before installation. R17's care plan dated 5/14/25, did not identify use of bed rails/grab bars. During observation on 6/4/25 at 8:40 a.m., R17 bed was observed to have bed rails/grab bars on both sides of the bed. R20: R20's quarterly MDS dated 3/5/25, identified no cognitive impairment and a diagnosis of Parkinson's disease (a progressive neurological disorder which affects movement, causing symptoms like tremors, stiffness, and slow movement). The MDS did not identify use of bed rails/grab bars. R20's care plan dated 5/9/25, did not identify use of bed rails/grab bars.	F 700		

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F 700	Continued From page 22 R6's medical record failed to identify a grab bar assessment to include entrapment risk, risk versus benefits, consent, bed dimentions in relation to the residents height and weight and what alternatives were attempted or containdicated before installation. During observation on 6/4/25 at 9:56 a.m., R20's bed was observed to have grab rails on both sides of the bed. During an interview on 6/4/25 at 1:18 p.m. director of nursing stated residents should have an assessment completed prior to installing and using grab bars. The facility's Bed Rail Mattress Guidelines revised 9/3/24, identified it was the policy of the facility to provide a safe environment for all patients and residents. It was a policy to adhere to the guidelines set forth by the FDA in regard to safe spacing of bed railings and mattresses. By following the FDA guidelines, we will have a reduced incidence of injury due to a patient/resident potentially becoming confined in a restricted area. However, the policy failed to direct staff to obtain an assessment for use prior to implementation.	F 700		

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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 6/2/25 through 6/4/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free from physical restraints while in bed for 2 of 2 residents (R8, R17) reviewed for restraints. Findings include: R8 R8's quarterly Minimum Data Set (MDS) dated 5/21/25, identified R8 had a mild cognitive impairment and had diagnoses that included history of a stroke, hallucinations, disorientation,	2 530	Corrected	6/26/25

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2 530	Continued From page 3 restlessness and agitation, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness). R8 was nonambulatory and required touching/supervision assistance for eating and was dependent on staff for all other care areas. The MDS identified no restraints were used for R8. R8's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 2/20/25, identified R9 was dependent on staff for most ADLs and R8 had left sided neglect from a stroke. R8's care plan revised 5/22/25, identified R8, on admit, did seem to be a low risk for falls/elopement. R8 was chair fast and could not move herself to transfer and could not walk. R8 required a full body mechanical lift for all transfers, but did move a little in bed at night. Staff were directed to place a pool noodle on the edge of R8's bed to prevent falls. R8's medical record failed to identify a restraint assessment for the use of the pool noodle. During an observation on 6/3/25 at 9:52 a.m., nursing assistant (NA)-A and NA-B assisted R8 to lie down in bed. NA-A and NA-B provided incontinence care for R8 and positioned R8 on her left side to be able to take a nap. At 10:00 a.m., NA-A covered R8 with a blanket then placed a pool noodle (a long foam cylinder approximately 5 feet in length and 3 inches in diameter) behind R8 underneath R8's fitted sheet. NA-A lowered R8's bed to the floor and exited R8's room. During an interview on 6/3/25 at 10:02 a.m., NA-A stated a pool noodle was put under the fitted sheet in case R8 rolled over so R8 couldn't fall on	2 530		

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2 530	Continued From page 4 the floor. During an observation on 6/4/25 at 9:10 a.m., NA-D and NA-E assisted R8 to lie down in bed. - At 9:19 a.m., NA-D placed the pool noodle under R8's fitted sheet and lowered R8's bed to the floor. During an interview on 6/4/25 at 9:27 a.m., NA-D stated, when R8 was first admitted, R8 would throw her legs out of bed and try to get up. Staff put the pool noodle under the fitted sheet to prevent R8 from doing that. NA-D stated R8 had never been seen trying to remove the pool noodle but R8 had left sided weakness and probably couldn't remove the pool noodle. During an interview on 6/4/25 at 10:08 a.m., registered nurse (RN)-A stated, when R8 was first admitted, R8 would throw her legs over the side of the bed to get out of bed. The pool noodle prevented R8 from doing that. RN-A stated R8 was unable to remove the pool noodle. RN-A's eyes widened then stated, "that's a restraint." R17 R17's quarterly Minimum Data Set (MDS) dated 2/26/25, identified severe cognitive impairment. R17 was dependent with bed mobility and transfers. The MDS identified restraints were not used with R17. R17's medical record failed to identify a restraint assessment for the use of the pool noodle. During observation on 6/4/25 at 8:40 a.m., trained medication assistant/nursing assistant (TMA)-A and TMA-B put R17 to bed. Once in bed TMA-A placed a pool noodle under the fitted sheet along	2 530		

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2 530	Continued From page 5 R17's left side. During an interview on 6/4/25 at 8:49 p.m., TMA-A stated R17 was not mobile but moved her legs around and toward the edge of the bed and was at risk to fall. R17 was a fall risk, and the pool noodle kept R17 in bed and R17 was not able to get over the pool noodle. During an interiew on 6/4/25 at 10:19 a.m., the director of nursing (DON) stated the pool noodle was a fall intervention. The DON stated she nor the staff considered the pool noodle could be a possible restraint and had not completed a restraint assessment. Residents should have been assessed to determine if there was an alternative option and/or how to use the restraint as safely as possible. A restraint policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON/designee, could ensure devices that are used for fall prevention are not a restrained, if it is determined it is a restraint than an assessment need to be completed prior to use along with physician order for a specific medical symtom and restraints used provide the least restrictive. The DON/designee could create policies and procedures, educate staff on these changes, and perform environmental rounds/audits periodically to ensure resident safety from entrapment is appropriately monitored. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (21)	2 530		

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2 530	Continued From page 6 days.	2 530		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 2 residents (R11, R27) reviewed for unnecessary medications; 2 of 2 residents (R8, R17) reviewed for restraints; and 7 of 7 residents (R4, R8, R26, R6, R10, R17, R20, R26) reviewed for grab bars. Findings include: MEDICATIONS: R11 R11's annual Minimum data set (MDS) dated 3/26/25, identified R11 had a moderate cognitive impairment and had diagnoses that included dementia, major depressive disorder, anxiety, and chronic obstructive pulmonary disease (COPD). R11used antipsychotic, antianxiety, and antidepressant medications. The MDS further identified R11 had not had a gradual dose reduction (GDR) or R11 had documented an indication for use.	2 550	Corrected	6/26/25

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2 550	Continued From page 7 R11's physician orders identified the following: - buspirone (antianxiety medication) 7.5 milligram (mg) tablet; take 1 tablet by mouth three times a day. - donepezil ((cholinesterase inhibitors) Donepezil is a medication primarily used to treat dementia associated with Alzheimer's disease. It helps improve cognitive functions such as attention, memory, and daily activities in patients with dementia. Donepezil is indicated for mild to severe dementia and may result in a small benefit in mental function.) Take 1 tablet at bedtime. - Lexapro (escitalopram oxalate) (antidepressant) 10 mg tablet; take 1 tablet by mouth daily. - mirtazapine (antidepressant) 15 mg tablet; take ½ tablet (7.5 mg) by mouth daily at bedtime. R11's physician orders failed to identify R11 used an antipsychotropic medication. R11's Pharmacy Monthly Medication Review dated 12/19/24, identified R11's medication regimen review was complete. No pharmacy recommendations at this visit. Dose of Remeron recently reduced due to daytime drowsiness and decreased appetite. R11 appeared to be tolerating dose reduction thus far and continued to be followed closely by psychiatry. R11 Psychiatry Provider Note dated 3/6/25, identified the following: R11's Psychiatric Problem History: Alzheimer's Dementia R11 presented with a history of memory impairment, moderate to severe in intensity, with additional impairments in executive functioning, learning, language, social cognition, as well as having visual perception problems, impacting the patient in all contexts of life and requiring structured living with nursing support. R11 met criteria for a DSM diagnosis of Major	2 550		

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	00353	A. BUILDING: _____ B. WING _____	06/04/2025

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2 550	Continued From page 8 Neurocognitive disorder/dementia, most likely of Alzheimer's type. Major Depressive Disorder R11 presented with an endorsement of depression symptoms occurring most days, moderate in intensity, affecting R11 in a number of contexts both at home and at work or when away from home. Symptoms included low mood, sadness, feelings of hopelessness, low energy, problems with concentration, appetite and sleep disturbance, and at times R11 would have feelings of low self-worth. The periods of depression were episodic, lasting two weeks or more, meeting the DSM criteria for Major Depression, recurrent. Generalized Anxiety Disorder (GAD) R11 presented with a recent history of ongoing daily anxiety symptoms with ruminative worry, tight muscles, initial insomnia, and autonomic arousal, occurring in a number of contexts, and meeting DSM criteria for GAD. Continue Buspar (buspirone)7.5 mg three times a day for Anxiety Lexapro 10 mg daily for MOD/anxiety Remeron (mirtazapine)7.5mg daily at bedtime for MDD/GAD - decreased 12/17/2024 Aricept (donepezil) 10mg daily at HS for dementia During an interview on 6/3/25 at 3:55 p.m., the director of nursing (DON) stated R11's MDS was incorrectly coded as R11 taking an antipsychotropic medication, R11 had GDR of Remeron, and her medications were clinically indicated by the psychiatrist. The MDS is important for payment reimbursement and to ensure GDR and documentation was correct. "It must have been missed." R27:	2 550		

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2 550	Continued From page 9 R27's admission MDS dated 3/11/25, identified R27 had diabetes mellitus and was receiving and anticoagulant (blood thinner). R27's physician order's dated 3/6/25, did not indicate R27 was on an anticoagulant. During an interview on 6/4/25 at 12/20 p.m., the DON stated when the resident was admitted they were not taking an anticoagulant and the admission MDS was coded in error and should have been reviewed. RESTRAINTS: R8 R8's quarterly MDS dated 5/21/25, identified R8 had a mild cognitive impairment and had diagnoses that included history of a stroke, hallucinations, disorientation, restlessness and agitation, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness). R8 was nonambulatory and required touching/supervision assistance for eating and was dependent on staff for all other care areas. The MDS further identified no restraints were used for R8. R8's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 2/20/25, identified R9 was dependent on staff for most ADLs and R8 had left sided neglect from a stroke. The MDS failed to identify R8 used a restraint. R8's care plan revised 5/22/25, identified R8, on admit, did seem to be a low risk for falls/elopement. R8 was chair fast and could not move herself to transfer and could not walk. R8	2 550		

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2 550	Continued From page 10 required a full body mechanical lift for all transfers, but did move a little in bed at night. Staff were directed to place a pool noodle on the edge of R8's bed to prevent falls. During an observation on 6/3/25 at 9:52 a.m., nursing assistant (NA)-A and NA-B assisted R8 to lie down in bed. NA-A and NA-B provided incontinence care for R8 and positioned R8 on her left side to be able to take a nap. At 10:00 a.m., NA-A covered R8 with a blanket then placed a pool noodle (a long foam cylinder approximately 5 feet in length and 3 inches in diameter) behind R8 underneath R8's fitted sheet. NA-A lowered R8's bed to the floor and exited R8's room. During an interview on 6/3/25 at 10:02 a.m., NA-A stated a pool noodle was put under the fitted sheet in case R8 rolled over so R8 couldn't fall on the floor. During an observation on 6/4/25 at 9:10 a.m., NA-D and NA-E assisted R8 to lie down in bed. - At 9:19 a.m., NA-D placed the pool noodle under R8's fitted sheet and lowered R8's bed to the floor. During an interview on 6/4/25 at 9:27 a.m., NA-D stated, when R8 was first admitted, R8 would throw her legs out of bed and try to get up. Staff put the pool noodle under the fitted sheet to prevent R8 from doing that. NA-D stated R8 had never been seen trying to remove the pool noodle but R8 had left sided weakness and probably couldn't remove the pool noodle. During an interview on 6/4/25 at 10:08 a.m., registered nurse (RN)-A stated, when R8 was first admitted, R8 would throw her legs over the side of the bed to get out of bed. The pool noodle	2 550		

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2 550	Continued From page 11 prevented R8 from doing that. RN-A stated R8 was unable to remove the pool noodle. RN-A's eyes widened then stated, "that's a restraint." R17: R17's quarterly MDS dated 2/26/25, identified R17 had severe cognitive impairment and was dependent on staff for bed mobility and transfers. The MDS identified R17 was not using restraints. R27's Restraints and Alarms assessment dated 2/26/25, identified resident R27 did not use restraints or alarms, and did not identfiy the use of a pool noodle R27's care plan dated 5/14/25, did not identify the use of restraints. During observation on 6/4/25 at 8:40 a.m., trained medication assistants (TMA)-A and TMA-B assisted resident to bed following breakfast. When R27 was in bed TMA-A placed a 3 inch high pool noodle under the fitted sheet on the left side of the bed. R27 was seen to have a long, raised area under the fitted sheet on the right side of the bed. R27 had side rails up on each side of the bed. During an interview on 6/4/25 at 8:50 a.m., TMA-A stated the pool noodles were used to keep R27 in her bed, R27 cannot get out of bed when the pool noodles were in place. During an interiew on 6/4/25 at 10:19 a.m., the director of nursing (DON) stated the pool noodles were for a a fall intervention. The DON stated she nor the staff considered the pool noodle could be a possible restraint and was not coded	2 550		

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2 550	Continued From page 12 on the MDS as a restraint. GRAB BARS/ BEDRAILS R4 R4's annual MDS dated 3/19/25, identified R4 had a severe cognitive impairment and had diagnoses that included dementia. R4 was nonambulatory, required substantial assistance for eating and was dependent on staff for all other care areas. The MDS did not identify R4 used grab bars. During an observation on 6/4/25 at 8:51 a.m., R4 did not use his bilateral bedrails to assist with turning nor did NA-C or NA-D encourage him to do so. R8 R8's quarterly MDS dated 5/21/25, identified R8 had a mild cognitive impairment and had diagnoses that included history of a stroke, hallucinations, disorientation, restlessness and agitation, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness). R8 was nonambulatory and required touching/supervision assistance for eating and was dependent on staff for all other care areas. The MDS further identified no restraints were used for R8. R8's Activities of Daily Living (ADLs) Functional/Rehabilitation Potential CAA dated 2/20/25, identified R9 was dependent on staff for most ADLs and R8 had left sided neglect from a stroke. The MDS failed to identify R8 used grab bars.	2 550		

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2 550	Continued From page 13 R8's care plan revised 5/22/25, identified R8, on admit, did seem to be a low risk for falls/elopement. R8 was chair fast and could not move herself to transfer and could not walk. R8 required a full body mechanical lift for all transfers, but did move a little in bed at night. The care plan failed to identify R8 used grab bars. During an observation on 6/3/25 at 9:52 a.m., NA-A and NA-B assisted R8 to lie down in bed. NA-A and NA-B provided incontinence care for R8 and positioned R8 on her left side to be able to take a nap. R8 did not use her grab bars to assist with turning and repositioning nor did NA-D or NA-E encourage her to do so. During an observation on 6/4/25 at 9:10 a.m., NA-D and NA-E assisted R8 to lie down in bed. R8 did not use her grab bars to assist with turning and repositioning nor did NA-D or NA-E encourage her to do so. During an interview on 6/4/25 at 9:27 a.m., NA-D stated R8 was unable to use her grab bars and staff completed turning for R8. R26 R26's quarterly MDS dated 4/30/25, identified R26 had a severe cognitive impairment and diagnoses that included epilepsy, generalized anxiety disorder, history of craniotomy (A craniotomy is a surgical procedure that involves removing part of the bone from the skull to expose the brain. The section of bone removed is called the bone flap, which is temporarily removed and then replaced after the brain surgery has been done. If the bone flap is not replaced, it is either a craniectomy (bone removed) or cranioplasty (non-osseous surgical	2 550		

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2 550	Continued From page 14 repair). R26 required supervision/touching assistance with personal hygiene, and partial/moderate assistance with toileting. The MDS did not identify R26 used grab bars. During an observation on 6/4/25 at 7:16 a.m., R26 was lying in bed, curled up in ball, with her face sticking out of the blankets. R26 was sleeping. A grab bar was connected to R26 bed on each side. During an observation on 6/4/25 at 1:03 p.m., R26's bed had grab bars on each side. R6: R6's quarterly MDS dated 3/19/25, identified no cognitive impairment and identified R6 had not used bed rails/grab bars or restraints. R6's care plan dated 5/16/25, identified R6 used the grab bars on both sides of the bed to turn and reposition. During observation on 6/4/25 at 9:56 a.m., R6's bed was observed to have grab bars on both sides of the bed. R10: R10's annual MDS dated 3/19/25, identified moderate cognitive impairment and diagnosis of a stroke. The MDS did not identify the use of bed rails/grab bars. R10's care plan dated 6/2/25, identified R10 used grab bars to reposition in bed. During observation on 6/4/25 at 1:17 p.m., R10's	2 550		

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2 550	Continued From page 15 bed was observed to have grab bars on both sides of the bed. R20: R20's quarterly MDS dated 3/5/25, identified no cognitive impairment and a diagnosis of Parkinson's disease (a progressive neurological disorder which affects movement, causing symptoms like tremors, stiffness, and slow movement). The MDS did not identify use of bed rails/grab bars. During observation on 6/4/25 at 9:56 a.m., R20's bed was observed to have grab rails on both sides of the bed. During an interview on 6/4/25 at 10:19 a.m., the DON stated the grab bars should have been coded on the MDS and were not. A facility policy related to MDS accuracy was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately completed. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete assessments. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement.	2 550		

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2 550	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		

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	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**06/04/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/04/2025. At the time of this survey, Mahnomen Health Center Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/20/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Mahnomen Health Center (Nursing Home) was built at three different times. In 1969 the main building was added to the east of the Mahnomen Hospital. It is 1-story, without a basement and is Type II(111) construction. In 1996 an addition to the north of the kitchen was added, is 1-story, no basement and Type II (111) construction, In 2000, additions of 1-story, without basements and of Type II(000) construction were built to the west of the 1969 building and to the north of the 1996 building, The 1969 building is separated by a	K 000		

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K 000	Continued From page 2 2-hour fire barrier from the Hospital building and from the 2000 east addition. The facility has 3 smoke compartments separated by at least 30 minute fire barriers. The facility is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems with quick response heads. The facility has a fire alarm system with corridor smoke detection, sleeping room smoke detection, and smoke detection in common areas in accordance with NFPA 72 "The National Fire Alarm Code." The facility has a capacity of 32 beds and had a census of 29 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 353 SS=E	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 _____ Provide in REMARKS information on coverage for	K 353		6/4/25

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K 353	Continued From page 3 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 inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5). These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 06/04/2025 at 9:39 AM, it was revealed by observation that a sprinkler head in the South Wing Tub Room was covered in a layer of lint and debris. 2. On 06/04/2025 at 9:46 AM, it was revealed by observation that a sprinkler head in the Main Kitchen Dish Room was covered in a layer of lint and debris. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 353	6-4-25: Sprinkler heads in Tub room and Kitchen were cleared of debris. Maintenance Director will monitor sprinklers for debris through QAPI. Maintenance staff will audit the sprinklers monthly to ensure debris does not build up.	
K 901 SS=D	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel.	K 901		6/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**06/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE MAHNOMEN, MN 56557**

(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 901	Continued From page 4 Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/04/2025 at 9:14 AM, it was revealed by a review of available documentation that the facility could not provide an NFPA 99 Risk Assessment for Chapters 5, 6, and 9 at the time of the survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 901	6-10-25: Risk assessment was completed. The risk assessment will be completed yearly.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 12, 2025

Administrator
Mahnomen Health Center
414 WEST JEFFERSON AVENUE
MAHNOMEN, MN 56557

RE: CCN: 245238
Cycle Start Date: June 4, 2025

Dear Administrator:

On July 10, 2025, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112