



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 30, 2026

Administrator
REGINA SENIOR LIVING
1175 NININGER ROAD
HASTINGS, MN 55033

RE: CCN: 245254

Cycle Start Date: February 26, 2026

Dear Administrator:

On April 23, 2026, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

The Minnesota Department of Health completed a revisit on April 22, 2026. Additionally, the Minnesota Department of Public Safety completed an on-site revisit on June 17, 2026, and an on-site Federal Monitoring visit on June 17, 2026, to confirm that your facility had attained and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 26, 2026, did not go into effect. (42 CFR 488.417 (b))

Feel free to contact me if you have questions.

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD , HASTINGS, Minnesota, 55033	
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E0000	Initial Comments On 2/23/26-2/26/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.	E0000		03/18/2026
F0000	INITIAL COMMENTS On 2/23/26-2/26/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52546623C (iQIES #2650224). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 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.	F0000		03/26/2026
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F0583	R29, R54, and R57 were interviewed regarding their privacy preferences. Resident care plans were updated to reflect their preferences. On 03/23/2026, the Executive Director (ED) procured privacy curtains designated for use during contracted clinical services conducted in the day room. These curtains will be deployed to ensure visual privacy and maintain resident dignity during the provision of care	04/21/2026

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 reverse for further 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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F0583 SS = D	<p>Continued from page 1</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review the facility failed to ensure privacy was maintained during treatments for 3 of 3 residents (R29, R54, R57) reviewed for privacy.</p> <p>Findings include:</p> <p>During an observation on 2/23/26 at 1:19 p.m., R57 was in the facility day room receiving podiatry (foot)cares. R54 and R29 were in the day room waiting for their podiatry appointments. Upon completion of foot care, R57 was removed from room by the podiatry medical assistant (MA)-A. MA-A returned and moved R54 so his foot cares could be completed. R29 remained in the day room during R54's podiatry treatments. Once completed R54 was assisted out of the room by facility staff. MA-A then moved R29 so she could have her podiatry cares completed. During R29's podiatry treatment, nursing staff and cleaning staff were</p>	F0583	<p>Continued from page 1 in non-traditional treatment areas.</p> <p>On March 26, 2026, the Executive Director provided formal written notification to the contracted podiatry provider outlining the requirement to maintain resident privacy during services conducted in non-traditional treatment areas to ensure compliance with resident rights to privacy and confidentiality.</p> <p>To ensure continued compliance, clinical staff and contracted providers will receive education on the Resident Rights and Notification of Resident Rights Policy (POL_SS003) with completion scheduled for April 14, 2026. The DON or designee is responsible for the education.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	

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F0583 SS = D	<p>Continued from page 2 walking through the day room. Upon completion, R29 was taken back to her room by facility staff.</p> <p>R29's quarterly Minimum Data Set (MDS) assessment, dated 1/8/26, indicated R29 had severe cognitive impairment. Further, R29 was dependent on facility staff for all cares. R29's diagnosis included neurocognitive disorder with Lewy-bodies Dementia (progressive neurodegenerative disease caused by abnormal protein deposits that destroy brain cells), chronic pain syndrome, and cognitive communication deficit.</p> <p>During an interview on 2/23/26 at 4:48 p.m., family member (FM)-A stated R29 would not have wanted to have her podiatry treatment performed with other residents around to watch. FM-A stated she has a lot of pain in her feet and would have wanted to have her podiatry treatments in private.</p> <p>R54</p> <p>R54's quarterly MDS assessment, dated 11/12/25, indicated R54 had no cognitive impairment. Further, R54 was independent with ambulation, toileting, and hygiene. R54's diagnosis included cellulitis (bacterial infection) of left lower limb, cellulitis of right second toe, and amputation of right lesser toe.</p> <p>During an interview on 2/23/26 at 5:10 p.m., R54 stated he would prefer to have his podiatry treatments done in his room.</p> <p>R57</p> <p>R57's comprehensive MDS assessment, dated 11/26/25, indicated R57 had limited cognitive impairment. Further, R57 required a wheelchair for mobility, set-up assistance for hygiene/oral care, and was independent with eating. R57's diagnosis included prostate cancer, chronic kidney disease, and difficulty walking.</p> <p>During an interview on 2/23/26 at 5:57 p.m., R57 stated he would prefer to do his podiatry treatments in a private space.</p> <p>During an interview on 2/23/26 at 1:34 p.m., MA-A stated the podiatry team comes to the facility every 9 weeks. MA-A stated the services provided include callus shaving and nail clipping. Podiatry treatments are done in the day room, unless the residents are not able to get out of bed then the podiatrist will go to the residents room.</p> <p>During an interview on 2/23/26 1:41 p.m., medical</p>	F0583		

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F0583 SS = D	Continued from page 3 doctor (MD)-A stated he provided podiatry services roughly every 9 weeks. The services he provided were callus shaving and nail clipping, occasionally helping with ingrown toenails if this can be treated safely at the facility. When asked how treatments are handled in the clinic setting the MD-A stated the treatments would be done in a private room at his clinic. The facility staff bring in multiple residents at a time. During an interview on 2/25/26 9:19 a.m., director of nursing (DON), administrator, and regional director of clinical services (RDCS) confirmed medical procedures or treatments such as wound care, optometry, dental, or podiatry should be done in private. Administrator confirmed the podiatry treatments done on 2/23/26 were conducted in the day room. Further, stating multiple residents can be in the day room during podiatry treatments. DON and RDCS confirmed the importance of completing podiatry treatments in a private setting to ensure resident privacy. An undated facility policy titled Resident Rights and Notification of Resident Rights, the facility will ensure a residents right to privacy and confidentiality.	F0583		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §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 . . . 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	F0605	R10 received an in-person, face to face evaluation with provider on February 26, 2026. The hospice case manager conducted a clinical review of the medication, and the PRN Haldol order was discontinued. To address residents potentially affected by this deficient practice, an immediate review of all residents receiving PRN antipsychotic medications was completed in collaboration with the attending providers and hospice partners. Any PRN antipsychotic orders lacking appropriate documentation, exceeding the 14-day limit, or without evidence of provider evaluation were promptly reviewed and either discontinued or updated to ensure compliance with facility policy. To ensure continued compliance, hospice providers and clinical staff received education on Psychotropic Medication Use Policy (POL_NS712) with completion scheduled for April 21, 2026. The DON or designee is responsible for the education. The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.	04/21/2026

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F0605 SS = D	<p>Continued from page 4 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must- . . .</p> <p>§483.12(a)(2) Ensure that the resident is free from chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. </p> <p>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.</p> <p>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>(1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>§483.45(e) Psychotropic Drugs. Based on a comprehensive</p>	F0605		

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F0605 SS = D	<p>Continued from page 5 assessment of a resident, the facility must ensure that--</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure an evaluation was completed prior to renewal of PRN (as needed) antipsychotic medications for 1 of 5 residents (R10) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R10's quarterly Minimum Data Set (MDS) assessment, dated 2/10/26 indicated R10 had severe cognitive impairment with a history of verbal behaviors. The MDS also indicated R10 was receiving hospice care and received antipsychotic medications (medications used to treat mental health disorders and behavioral</p>	F0605		

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F0605 SS = D	<p>Continued from page 6 disturbances).</p> <p>R10's diagnoses list included, unspecified dementia, cognitive communication deficit, anxiety, protein-calorie malnutrition.</p> <p>R10's care plan indicated mood state related to diagnosis of anxiety and restlessness and agitation, high risk medications including Haloperidol (antipsychotic medication), hospice services, and cognitive loss related to dementia.</p> <p>R10's medication administration record indicated R10 received haloperidol 1 mg every 4 hours PRN from 1/26-2/8 (21 doses given), haloperidol 1 mg every 1 hour 2/10-2/12 (4 doses given), and haloperidol 1 mg every hour 2/12-2/15 (8 doses given).</p> <p>R10's hospice enrollment history and physical signed by the hospice provider dated 1/19/26 indicated terminal illness attestation "based on my review of this patient's available medical record and discussion with the hospice admission nurse."</p> <p>R10's hospice orders dated 1/20/26 indicated a verbal order for haloperidol 0.5 mg every 4 hours as needed for confusion, restlessness, agitation, nausea with a hand written stop date of 2/2/26.</p> <p>R10's hospice orders dated 1/26/26 indicated a verbal order for haloperidol 1 mg by mouth every 4 hours as needed for agitation and hallucinations with a hand written stop date of 2/8.</p> <p>R10's hospice orders dated 2/10/26 indicated a verbal order for haloperidol 1mg every hour PRN agitation with a stop date 2/23/26.</p> <p>R10's medical record indicated R10 was seen by the facility provider on 1/8/26. R10's record indicated hospice provider last seen 1/20/26.</p> <p>During an interview on 2/25/26 at 2:34 p.m., licensed practical nurse (LPN)-A stated residents who receive as needed antipsychotic medications are seen by a provider every 14 days. LPN-A stated the facility has updated the hospice provider several times of the requirement residents must be seen face to face every 14 days when receiving an PRN antipsychotic medication. LPN-A verified, R10 was seen by the hospice provider on 1/20/26, the facility provider on 1/8/26, and an acute visit by the facility nurse practitioner on 2/19/26.</p> <p>During an interview on 2/26/26 at 8:36 a.m., the</p>	F0605		

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F0605 SS = D	<p>Continued from page 7 hospice registered nurse (HRN) stated R10 enrolled in hospice 1/20/26 and is seen weekly by nursing staff. HRN confirmed R10 is receiving scheduled and as needed haloperidol. She stated hospice manages the medication however it is the facility's responsibility to determine if the resident is having breakthrough issues. The haloperidol is ordered every two weeks based on a mutual discussion between herself, facility staff, and if needed, the hospice medical provider. Hospice providers are involved in the interdisciplinary meeting to recertify a resident every 90 days, however, do not begin seeing residents until after their second 90 day recertification. At that time, the hospice provider will see the resident face to face every 8 weeks. Hospice providers do not see the resident face to face to re-order as needed antipsychotic medications.</p> <p>During a joint interview on 2/26/26 at 10:54 a.m., with the facility director of nursing (DON) and the Regional Director of Clinical Services (RDCS), the DON stated PRN antipsychotic medications are "good for 14 days" and the facility will automatically put a stop date. The DON stated hospice is the one managing R10's PRN haloperidol and would be the ones to see R10 in person. The DON and RDCS reviewed R10's medical records and could not provide documentation R10 received a face-to-face visit by a provider every 14 days.</p> <p>A policy titled "Psychotropic Medication Use" dated 9/7/23 indicated parameters required for antipsychotic medications that included "PRN anti-psychotic orders are limited to 14 days and cannot be renewed unless the attending provider evaluates the resident for the appropriateness of that medication." It continued "Documentation will reflect implementation of the above" [referring to the list of required parameters].</p>	F0605		
F0656 SS = D	<p>Develop/Implement Comprehensive Care Plan</p> <p>CFR(s): 483.21(b)(1)(3)</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p>	F0656	<p>On February 24, 2026, the Interim Director of Nursing (DON) conducted a comprehensive review of the care plans for R24 and R33. Care plans were updated and revised as indicated to accurately reflect each resident's current condition, needs, and plan of care.</p> <p>A facility-wide audit of all resident care plans was initiated on Feb. 24, 2026 to ensure compliance with comprehensive care planning requirements.</p> <p>To ensure continued compliance, Nurse Managers, MDS Nurse, and staff nurses will be educated on the Comprehensive Assessments and Care Planning Policy (POL_NS101) with completion scheduled for April 21,</p>	04/21/2026

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F0656 SS = D	<p>Continued from page 8</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, observation and record review, the facility failed to develop a person-centered care plan for 2 of 2 residents (R24, R33) reviewed for care planning.</p> <p>Findings include:</p> <p>R33's Admission Minimum Data Set (MDS) assessment, dated 1/14/26, /indicated intact cognition. R33 /required /substantial /assistance /with toileting and bed mobility, was occasionally incontinent of bladder and continent of bowel. R33 was at risk for a pressure</p>	F0656	<p>Continued from page 8</p> <p>2026. The DON or designee is responsible for the education.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	

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F0656 SS = D	<p>Continued from page 9 ulcer, had no pressure ulcer/injury on admission. R33 had a pressure /reducing device for chair and bed.</p> <p>R33's diagnoses /included, cerebral /infarction (CVA) (blood clot in the brain), pressure induced deep tissue damage of left /heel, /chronic systolic (congestive) heart failure /(a serious condition of the heart's ability to pump blood efficiently), and edema (swelling).</p> <p>R33's admission /skin risk assessments, dated 1/8/26 indicated at risk for pressure ulcers with an intervention to reposition every two to three hours.</p> <p>R33's /care plan dated /1/12/26, /indicated R33 /needs /assistance with bed mobility, transfers, ambulation, and locomotion due to CVA. Interventions included assist /to turn and reposition.</p> <p>R33's record lacked the implementation of a care plan for risk of developing pressure ulcers and injuries.</p> <p>R33's mobility care plan dated 1/12/26, indicated R33 needs assist with bed mobility, transfers, ambulation, and locomotion due to CVA. Intervention dated 1/12/26, per skin care plan was to assist with turning and repositioning, although R33 care plan lacked a skin section care plan.</p> <p>R33's Care Sheet dated 02/24/26 lacked interventions to prevent developing pressure ulcers and injuries.</p> <p>During an interview with R33 on 2/24/26 at 4:05 p.m., R33 denied being assisted with frequent repositioning in bed and or chair.</p> <p>During an interview on 2/24/26 at 2:26 p.m., nursing assistant (NA)-B stated being unsure of R33 turning and reposition schedule. NA-B stated the schedule should be in point of care for charting and on the care sheet in a binder at the nursing station.</p> <p>During an interview on 2/25/26 at 8:34 a.m., director of nursing (DON) stated, there was no skin category or risk for pressure ulcer on R33's care plan.</p> <p>R24</p> <p>R24's quarterly Minimum Data Set (MDS) assessment dated 12/3/25, indicated R24 had no cognitive impairment. R24 required a walker for ambulation and was independent with eating, hygiene, and dressing. R24's diagnosis included COPD (progressive and irreversible lung disease causing shortness of breath), emphysema</p>	F0656		

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F0656 SS = D	<p>Continued from page 10 (progressive lung disease that causes damage to the air sacs in the lungs), and chronic respiratory failure with lack of oxygen.</p> <p>R24 record dated 2/13/26 was admitted to hospice.</p> <p>R24's comprehensive care plan lacked patient-centered hospice care plan.</p> <p>During an interview on 2/24/26 at 10:17 a.m., nursing assistant (NA)-A stated she is unsure why R24 was put on hospice. NA-A indicated there is a hospice binder although that includes just hospice numbers and miscellaneous. NA-A stated she was unsure what end-of life preferences R24 wanted.</p> <p>During an interview on 2/24/26 at 10:51 a.m., director of nursing (DON) and regional director of clinical services (RDCS) stated after the resident chooses a hospice company, the hospice banner is added in the electronic medical record (EMR), hospice contact information is added to the resident profile, and the resident care plan. The hospice care plan would include the hospice company information, hospice diagnosis, and any known resident choices and preferences. DON confirmed R24 was admitted to hospice on 2/13/26 and R24's care plan did not have a hospice care plan. DON and RDCS stated the hospice care plan is important, so all staff are aware of the resident status and how to care for them during the end-of-life stage.</p> <p>A facility policy titled Comprehensive Assessments and Care Planning dated 9/27/23, the facility will provide a comprehensive person-centered interdisciplinary care plan.</p>	F0656		
F0755 SS = D	<p>Pharmacy Srvcs/Procedures/Pharmacist/Records</p> <p>CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet</p>	F0755	<p>Physician orders for R1 and R54 were immediately reviewed on 02/26/2026 by the Director of Nursing (DON)/designee. The order was verified for accuracy, and medication availability in the ADU was confirmed. The resident was assessed for any adverse outcomes related to the delay, and no negative clinical impact was identified.</p> <p>All physician orders from the past 30 days were reviewed for all facility residents to ensure timely transcription and verification, medication availability, and absence of delays related to ADU dispensing or pharmacy delivery.</p> <p>To ensure continued compliance, education will be provided to licensed nurses and Health Unit</p>	04/21/2026

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F0755 SS = D	<p>Continued from page 11 the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 2 of 2 residents (R1, R54) reviewed for pharmacy services.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 12/9/25, indicated R1 was cognitively intact with no behaviors, have pressure reducing devices, nutritional supplementation, and dressings. R1 was independent with eating, set up for oral hygiene and required assistance for all activities of daily living.</p> <p>R1's care plan indicated R1 had wounds to both feet, impaired cardiac output, enhanced barrier precautions related to wounds, and diabetes,</p> <p>R1's diagnoses list included, cerebral palsy (brain disorder causing decreased muscle coordination) , peripheral vascular disease (disorder affecting circulation in the arms and legs), diabetes (disorder affecting blood sugar levels), respiratory failure (disorder affecting breathing), lymphedema (disorder causing fluid collection under the skin), and venous insufficiency(disorder that causes blood to pool in the legs instead of returning to the heart).</p> <p>R1's provider orders included:</p>	F0755	<p>Continued from page 11 Coordinators (HUCs) on order transcription and verification expectations, including: Orders must be entered and verified same day, or by next morning if received late, with completion scheduled for April 21, 2026. The DON or designee is responsible for the education.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	

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F0755 SS = D	<p>Continued from page 12 wound care: right dorsal [top] foot every other day and as needed (PRN)</p> <p>Sprinkle metronidazole [medication used to treat fungal infection] 500 mg crushed tablet into wound bed every other day.</p> <p>R1's medical record indicated the following:</p> <p>2/5/26-Wound Clinic provider wrote order for Metronidazole 500 mg to wound every other day</p> <p>2/6/26-health unit coordinator entered order into electronic medical record</p> <p>2/9/26-order was confirmed by facility nursing staff adding the location to apply metronidazole</p> <p>2/10/26-R1's medication administration record (MAR) indicated medication was not given with a progress note stating "Metronidazole currently unavailable. Writer left a message with pharmacy to see if this could be ordered."</p> <p>2/12/26-medication was signed off as given however facility progress note indicated "Metronidazole currently unavailable. Spoke with Rx (pharmacy), 30 day supply was delivered on 2/2 and 5 tablets were delivered on 2/5."</p> <p>2/16/26-MAR indicated metronidazole was not given</p> <p>2/17/26-facility progress note indicated "pharmacy to deliver metronidazole tonight for dressing changes to right foot."</p> <p>2/19/26-Wound nurse practitioner provider note indicated "metronidazole still hasn't come in or been applied. Nurse manager is going to look into Flagyl [metronidazole]"</p> <p>2/22/26-MAR indicated metronidazole was not given</p> <p>During an interview on 2/25/26 at 2:38 p.m., licensed practical nurse (LPN-A) confirmed R1 had chronic wounds to both feet that were followed by the wound clinic. LPN-A reviewed R1's MAR and confirmed dates metronidazole was not administered. LPN-A stated the medication should be in the automated dispensing unit (ADU) (machine used to dispense certain medications).</p> <p>During an interview on 2/25/26 at 3:31 p.m., the wound clinic nurse practitioner (NP)-B confirmed R1 had chronic wounds to both feet that are difficult to heal</p>	F0755		

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F0755 SS = D	<p>Continued from page 13 due to his diagnosis of venous insufficiency. NP-B stated she saw R1 for several months before referring R1 to the vascular clinic (clinic that treats circulatory issues). NP-B stated she started seeing R1 again "2-3 weeks ago". On 2/5 NP-B ordered metronidazole to R1's right foot due to a possible fungal infection. NP-B confirmed she saw R1 on 2/5, 2/12, and 2/19 and the metronidazole was not available at each visit. NP-B stated the medication "had to be reordered last week".</p> <p>During an interview on 2/25/26 at 4:00 p.m., licensed practical nurse (LPN)-B confirmed R1's treatment order included metronidazole 500 mg to right foot. LPN-B recalled 1 day the medication was not available and a message was left to the pharmacy to deliver. LPN-B stated the next day a supervisor told her the medication was located in the ADU.</p> <p>During observation and interview on 2/25/26 at 4:15 p.m., a tall locked cabinet was noted in the medication room. LPN-A stated staff log into the computer in order to dispense medications. A list of available medications was located on the front of the machine which included metronidazole 500 mg tablets.</p> <p>During interview on 2/26/26 at 9:15 a.m., LPN-C stated new orders received from the provider are given to the health unit coordinator to enter and then verified by a nurse the same day. If the order is received on the night shift, it will be verified the next morning. LPN-C stated if a medication is not available in the medication cart, she would see if the medication were available in the ADU. If it is not, she would update the nurse manager and let the provider know a dose was missed.</p> <p>During an interview on 2/26/26 at 11:07 a.m., the pharmacy tech (tech) stated if a medication isn't available in the ADU the pharmacy will send a separate bubble pack card to the facility containing the medication. If the ADU is out of medication, the facility must request it because the pharmacy is not automatically alerted. The tech stated they received the order for metronidazole for R1 on 2/9/26 however the original date is 2/6/26. The tech stated metronidazole was dispensed from the ADU on 2/14, 2/20, 2/22, and 2/23 and confirmed no metronidazole was dispensed from the machine from 2/9-2/13.</p> <p>A report received from the facility and the pharmacy confirms the dates of metronidazole was removed from the ADU.</p>	F0755		

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F0755 SS = D	<p>Continued from page 14</p> <p>During a joint interview with the director of nursing (DON) and Regional Director of Clinical Services (RDCS) on 2/26/26 at 11:18 a.m., the DON stated new orders are transcribed in the electronic medical record by either the health unit coordinator or a nurse and verified by a nurse. The DON stated she expects orders to be entered and verified the same day they are received. If an order is received late, she would expect it to be verified by the next morning. If a medication is not available, staff are expected to call the pharmacy, and update the provider. Some medications are available in the ADU or the e-kit (emergency kit). The DON and RDCS verified the order for metronidazole was dated 2/5/26 and entered on 2/6/26 by the HUC however was not verified until 2/9/26. The DON stated she would have expected the metronidazole order to be processed by the next day. The DCS stated some medications are automatically dispensed via the ADU and some are sent from the pharmacy in bubble packs. Night nurses obtain all scheduled medications from the ADU and disperse them in the appropriate medication carts for the following day. If a medication is not scheduled to be dispensed, nurses do have the ability to manually request the ADU to dispense a medication. The DON stated she was first made aware of the missing metronidazole on 2/19/26 and verified the medication was in the ADU. The DON stated she spoke to the pharmacy on 2/25/26 who stated the metronidazole was officially loaded to be dispensed on 2/12/26 however the machine didn't start automatically dispensing it until 2/20/26.</p> <p>A policy titled "Medication Ordering and Receiving From Pharmacy" dated 12/2017 did not reference the ADU machine.</p> <p>A policy regarding processing of provider orders was requested and not received.</p> <p>R54</p> <p>R54's quarterly Minimum Data Set (MDS) assessment dated 11/12/25, indicated R54 had no cognitive impairment. Further, R54 was independent with ambulation, toileting, and hygiene. R54's diagnosis included cellulitis (bacterial infection) of left lower limb, cellulitis of right second toe, and amputation of right lesser toe.</p> <p>R54's care plan for skin has issues related to left lower limb cellulitis, right foot amputation, and skin tears. Interventions included moisture barrier and creams to be used to protect skin.</p>	F0755		

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F0755 SS = D	<p>Continued from page 15 R54's record indicated the following:</p> <p>2/12/26 R54 was prescribed 25% urea lotion to both feet twice daily.</p> <p>2/12/26 at 10:14 p.m., progress note recognizing new prescription of 25% urea lotion, additionally from pharmacy: this is on over the counter (OTC) medication and pharmacy will not be providing it.</p> <p>2/19/26 at 2:23 p.m., progress note between pharmacy and facility, 25% urea lotion had been moved to the non-transcribed file at the pharmacy, facility requested immediate delivery of medication, additionally from pharmacy: they do not carry the specific percent of urea lotion-would need further clarification from ordering provider.</p> <p>2/21/26 at 10:09 p.m., progress note between pharmacy and facility, pharmacy only carries 20% or 40% urea lotion, please clarify with ordering provider. Message sent to triage to send new orders for urea cream.</p> <p>2/23/26 at 8:38 a.m., new order written for R54 for 20% urea cream to both feet twice per day.</p> <p>2/23/26 at 12:19 p.m., progress note, new orders received from triage for 20% urea cream to both feet twice per day. Order transcribed into electronic medical record (EMR).</p> <p>During observation on 2/23/26 at 1:19 p.m., R54 was observed in facility day room receiving podiatry cares. Medical doctor (MD)-A asked R54 if he had been using the urea lotion on his feet twice per day. R54 stated, he had not been using any lotion on his feet because the facility had not gotten the lotion yet. MD-A stated R54 needs the lotion to help reduce the dryness of his feet. R54 stated he didn't know when the facility would get the lotion.</p> <p>During a joint interview on 2/25/2026 at 2:08 p.m., director of nursing (DON), administrator, and regional director of clinical services (RDCS), DON stated new orders are typically ordered by the health unit coordinator (HUC) and a nurse verifies the orders. Further to this, orders should be completed and ready within 24 hours. RDCS stated the initial urea lotion order was received on 2/12/26 and confirmed there were issues with processing due to order clarification. DON stated the medication was reordered on 2/23/26 and was not available for use. DON stated it is important to obtain medications when ordered so residents can begin treatments as expected.</p>	F0755		

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F0755 SS = D	Continued from page 16	F0755		
F0757 SS = D	<p>A facility policy titled Medication Ordering and Receiving from Pharmacy dated 12/17, medications and related products are received from the dispensing pharmacy on a timely basis.</p> <p>Drug Regimen is Free from Unnecessary Drugs</p> <p>CFR(s): 483.45(d)(1)-(6)</p> <p>§483.45(d) Unnecessary Drugs-General.</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to monitor for effectiveness of a medication prescribed for sleep for 1 of 5 residents (R47) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R47's Minimum Data Set (MDS) assessment, dated 12/2/25 identified R47 had no cognitive impairment, had lower extremity impairment on one side, maximum assistance with transfer and bed mobility, independent with toilet transfer, incontinent of bowel</p>	F0757	<p>On February 26, 2026, the Health Unit Coordinator (HUC) completed a review of sleep monitoring orders for R47. The order was updated as indicated to ensure accuracy, appropriateness, and alignment with the resident's current plan of care.</p> <p>A facility-wide audit was initiated on Feb. 26, 2026 of all residents with sleep monitoring orders to ensure orders are current, complete, and clearly defined. Any discrepancies were corrected immediately.</p> <p>To ensure continued compliance, Nurse Managers, floor nurses and HUC will receive education on sleep monitoring expectations, with completion scheduled for April 21, 2026. The DON or designee is responsible for the education.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	04/21/2026

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F0757 SS = D	<p>Continued from page 17 and bladder.</p> <p>R47 diagnoses include polyneuropathy (a condition in which multiple peripheral nerves are damaged, leading to weakness, numbness and impaired function in various parts of the body), type 2 diabetes, major depressive disorder, anxiety, obstructive sleep apnea, and laceration to /right /great toe.</p> <p>R47's medication orders included: Melatonin tablet 5 milligram (mg), oral at bedtime: Start date 11/22/24.</p> <p>R47's Medication Administration Record (MAR) record review from 1/01/26 to 1/31/26 and 2/01/26 to 2/25/26 indicated medication was administered.</p> <p>R47's record lacked sleep tracking or monitoring assessment.</p> <p>During an interview on 2/26/2026 at 8:10 a.m., the director of nursing (DON) confirmed R47 taking melatonin 5 mg by mouth at bedtime for sleep. DON stated, sleep tracking was only initiated when ordered by the prescribing provider. DON also stated, sleep tracking would have been available in progress if it was ordered. Progress note review from 12/01/25 to 02/26/26 showed no sleep tracking notes.</p> <p>A facility policy on monitoring sleep was requested and not received.</p>	F0757		
F0812 SS = F	<p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from</p>	F0812	<p>1. Corrective Action for Affected Areas</p> <p>All food boxes were immediately removed from the walk-in freezer floor and properly stored on shelving units at least six inches off the floor.</p> <p>The paper bowl used as a scoop was removed and discarded.</p> <p>The can opener (blade and gear) was removed, thoroughly cleaned, and sanitized.</p> <p>Culinary staff were immediately re-educated on proper sanitation procedures, appropriate utensil use, and food storage requirements.</p> <p>2. Identification of Other Potentially Affected Areas</p> <p>All culinary staff received re-education on food safety and sanitation practices.</p>	04/21/2026

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F0812 SS = F	<p>Continued from page 18 consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to clean and sanitize food-contact equipment, remove a paper bowl used as a scoop in a sugar container and keep food boxes off walk-in freezer unit floor.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 2/23/26 at 12:15 p.m., with the culinary director (CD), the following was identified: seven boxes were stored on the Walk-in freezer floor, a brown paper bowl used as scoop left in the sugar container and the can opener part that meets the top of the can (blade and gear) was covered with dark dry substance. CD confirmed the scoop in the sugar container, is not the usual practice indicated it could cause for cross contamination.</p> <p>During a follow up kitchen tour 2/25/26 at 7:52 a.m., the can opener blade and gear remained covered with the dark dry substance and additionally a red paste was noted on the blade. Head cook (HC) indicated it was used and must have gotten dirty yesterday.</p> <p>In the walk-in freezer, five food boxes remained on the floor. HC stated the boxes were not supposed to be on the floors and were delivered the day prior.</p> <p>During an interview on 2/25/26 at 8:46 a.m., CD stated, the expectation was for the can opener to be cleaned weekly, when asked about the substance covering the can opener blade and gear-can remove this. CD confirmed, (could remove this also) and the boxes in the walk-in freezer should not be on the floor.</p> <p>A facility policy on food safety procedures was requested and not received.</p>	F0812	<p>Continued from page 18</p> <p>A full kitchen audit was conducted, including review of all food-contact equipment, storage containers, scoop usage, and food storage practices.</p> <p>All storage areas, including delivery processes, were reviewed to ensure compliance with proper storage standards.</p> <p>3. Systemic Changes</p> <p>The daily cleaning task list was updated to include required daily cleaning and sanitizing of the can opener, with staff sign-off required each shift.</p> <p>The Food Safety and Sanitation Policy was reviewed, updated as needed, and redistributed to all culinary staff, with required acknowledgment of understanding.</p> <p>Staff were re-educated on proper scoop usage, including approved utensils and appropriate storage of scoops.</p> <p>Staff were re-educated on proper food storage practices, including maintaining all items at least six inches off the floor. This requirement has been added to daily and delivery checklists.</p> <p>4. Monitoring and Sustaining Compliance</p> <p>The Culinary Director or designee will conduct audits three (3) times per week for two (2) weeks, then two (2) times per week for two (2) weeks, followed by one (1) time per week for two (2) weeks.</p> <p>Audits will include review of equipment cleanliness, proper utensil usage, and food storage compliance.</p> <p>Any identified issues will be corrected immediately, with additional staff re-education as needed.</p> <p>Audit results will be reviewed through the facility's QAPI process to ensure ongoing compliance.</p>	
F0880 SS = E	<p>Infection Prevention & Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p>	F0880	<p>On February 25, 2026, immediate corrective action were taken to ensure proper infection control practices for R33, R57, and R66. No residents were identified as having adverse outcomes related to the deficient</p>	04/21/2026

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 02/26/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD , HASTINGS, Minnesota, 55033</p>		
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<p>F0880 SS = E</p>	<p>Continued from page 19 §483.80 Infection Control</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with</p>	<p>F0880</p>	<p>Continued from page 19 practice.</p> <p>A facility-wide review was conducted on February 25, 2026, of all residents on transmission-based or enhanced barrier precautions to ensure appropriate PPE signage was in place and available for staff adherence to required PPE use.</p> <p>To ensure continued compliance, all licensed nurses, CNAs, and ancillary staff (including therapy and contracted providers) will receive education on PPE requirements specific to COVID-19 isolation (Covid Policy Manual) and Enhanced Barrier Precautions (POL_IP060) with completion scheduled for April 14, 2026. The DON or designee is responsible for the education.</p> <p>Standardized MDH-approved PPE signage has been implemented facility-wide for all isolation rooms.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	

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F0880 SS = E	<p>Continued from page 20 residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to correctly establish and ensure staff followed appropriate transmission-based precaution (TBP) for 1 of 1 resident (R66) who required enhanced respiratory precautions for COVID-19. Further, the facility failed to ensure appropriate personal protective equipment (PPE) was used for residents in enhanced barrier precaution (EBP) during podiatry treatments in a common area for 1 of 3 residents (R57) reviewed for EBP. Additionally, the facility failed to initiate EBP for 1 of 1 resident (R33) who required EBP due to a pressure ulcer.</p> <p>Findings include:</p> <p>R66 was admitted to the facility on 2/20/26 from a hospital, her Minimum Data Set (MDS) assessment had not been completed at time of survey.</p> <p>R66's progress note dated 2/21/26 indicated R66 had severe cognitive impairment. R66 had a diagnosis of dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and Covid-19.</p> <p>According to the Centers for Disease Control (CDC), residents diagnosed with COVID-19 require additional</p>	F0880		

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F0880 SS = E	<p>Continued from page 21 TBP that included an isolation gown, N95 respirator or higher-level respirator, eye protection (goggles or face shield), and gloves.</p> <p>During observation on 2/24/26 at 10:52 a.m., physical therapy (PT)-A was observed entering R66's room with a standard mask (not an N95) and without an isolation gown or gloves, placed a gait belt in her room and exited room.</p> <p>During an interview on 2/24/26 at 11:08 p.m., PT-A stated he had only put on a standard mask (not an N95) when he returned the gait belt to the room he had used when working with R66. PT-A stated when returning the gait belt, he should have put on the appropriate PPE before entering the room that included the isolation gown, N95 mask, and gloves. PT-A stated it is important to wear the appropriate PPE every time you enter the room to prevent the spread of infection.</p> <p>During observation on 2/26/26 at 9:08 a.m., nursing assistant (NA)-C was delivering the meal tray to R66. NA-C put on an isolation gown, standard mask (not an N95), gloves, and eye protection. NA-C opened R66's door, walked inside room with meal tray and closed the door. At 2/26/26 at 9:11 a.m., NA-C exited R66's room, performed hand hygiene, then moved down hall to continue delivering meal trays.</p> <p>During an interview on 2/26/26 at 10:11 a.m., licensed practical nurse (LPN)-E stated they receive infection control education upon hire, annually, and if something changes. LPN-E stated the infection control education contains information about proper PPE for the different types of infections they see at the facility. LPN-E stated for a resident who was in isolation for COVID-19, the isolation required included an isolation gown, gloves, face mask, and an N95 mask. LPN-E stated staff should wear the appropriate PPE every time you enter the room of someone with COVID-19; this is important to prevent the spread of infection.</p> <p>During an interview on 2/26/26 at 10:17 a.m., NA-C stated staff receive education about infection prevention when they are hired, annually, and if something changes. NA-C stated the infection prevention education they received included how to apply and take off PPE, when to use PPE, and what type of PPE to use for the infections they typically see in the facility. NA-C stated the proper PPE to use when caring for someone with COVID-19 included an N95 mask, isolation gown, gloves, and goggles. NA-C stated she had been delivering morning meal trays that included R66. NA-C stated she was aware R66 had been diagnosed with</p>	F0880		

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F0880 SS = E	<p>Continued from page 22 COVID-19 and required additional PPE for that. NA-C confirmed she had not had a N95 mask on when delivering R66's meal tray. NA-C stated she did not wear the N95 mask because the isolation sign on the door stated she could wear an N95 mask or a standard mask. NA-C stated she thought residents with COVID-19 infections required an N95 mask but since the sign said she could wear a standard mask, that is why she wore the standard mask.</p> <p>During observation and interview on 2/26/26 at 10:28 a.m., director of nursing (DON) and regional director of clinical sales (RDCS) confirmed R66 had COVID-19; requiring additional PPE that would include an N95 mask, isolation gown, face mask, and gloves. RDCS confirmed staff are educated about isolation procedures when they are hired, yearly, and if there are any updates to isolation procedures. DON stated it is her expectation all staff at the facility should wear the appropriate PPE prior to entering R66's room. Additionally, DON and RDCS reviewed the isolation sign placed on R66's door, the isolation sign reflected staff would be required to wear:</p> <ul style="list-style-type: none"> -Gown -Facemask or -N95 Respirator for aerosol-generating procedures -Eye protection (goggles or face shield) -One pair of gloves -Hair cover (optional) <p>DON and RDCS confirmed the isolation sign currently on R66's door was not the correct sign; they were unsure where this sign came from or how it was placed on R66's door. RDCS stated the correct sign the facility uses read:</p> <ul style="list-style-type: none"> -Gown -N95 Respirator or higher-level respirator - Eye protection (goggles or face shield) -One pair of gloves <p>DON and RDCS stated it is important to apply the appropriate PPE to prevent the spread of infection. Additionally, the appropriate PPE should be worn every time facility staff enter R66's room.</p>	F0880		

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F0880 SS = E	<p>Continued from page 23</p> <p>R57</p> <p>R57's comprehensive MDS assessment, dated 11/26/25, indicated R57 had limited cognitive impairment . Further, R57 required a wheelchair for mobility, required set-up assistance for hygiene/oral care, and was independent with eating. R57's diagnosis included prostate cancer, chronic kidney disease requiring a urinary catheter (tube inserted into the body to drain urine), and difficulty walking.</p> <p>R57's care plan dated 11/11/24, had previously acquired infections and due to the placement of the urinary catheter, R57 now required EBP when receiving cares.</p> <p>During observation on 2/23/26 at 1:24 p.m., R57 was observed in the facility day room with 3 other residents; all 3 residents were receiving podiatry care. The podiatry team did not put on the appropriate PPE when providing treatment to R57; as recommended by the CDC. Medical doctor (MD)-A donned standard gloves removed R57's shoes and socks, performed callous shaving and clipping toenails. When completed, medical assistant (MA)-A assisted R57 with putting his shoes and socks back on; MA-A had not applied the appropriate PPE prior to assisting him.</p> <p>During an interview on 2/23/26 at 1:24 p.m., MA-A stated she was unsure if R57 required staff to wear special PPE when providing podiatry treatments. MA-A stated the podiatry team does not wear PPE when providing treatment, unless facility staff direct them to. MA-A stated she had not worn any additional PPE while caring for any of the residents today.</p> <p>During an interview on 2/23/26 at 1:41 p.m., MD-A stated he was unaware that R57 required podiatry staff to wear additional PPE when providing podiatry treatments. MD-A stated his team primarily performs callous removal and toenail clipping. MD-A stated he was aware of why residents would require additional PPE such as required for EBP; the primary reason being to reduce the spread of infection from one resident to another. When asked if residents in EBP or higher-level isolation should have podiatry treatments in a common area; MD-A stated only bed bound residents get podiatry care in their rooms. MD-A stated he would prefer the day room to be a private setting but, facility staff kept bringing more residents into the room.</p> <p>During an interview on 2/25/26 at 9:19 a.m., director of nursing (DON), regional director of clinical sales (RDCS), and administrator stated they would expect all</p>	F0880		

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F0880 SS = E	<p>Continued from page 24 ancillary service providers to adhere to the facility's infection prevention precautions such as EBP. The administrator confirmed he had walked through the day room during the podiatry treatments, PPE was not worn for residents receiving podiatry treatments. DON and RDCS stated it is important to apply the appropriate PPE to prevent the spread of infection. Additionally, the appropriate PPE should be worn every time facility staff or ancillary staff provide cares such as podiatry treatments.</p> <p>A facility policy titled COVID-19 Program Overview dated 9/29/22, healthcare workers caring for residents with suspected or confirmed COVID-19 should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator.)</p> <p>A facility policy titled Enhanced Barrier Precautions dated 4/1/24, residents with indwelling medical devices (such as a urinary catheter) require EBP when providing hygiene cares.</p> <p>R33</p> <p>R33's Admission Minimum Data Set (MDS) assessment, dated 1/14/26, indicated, intact cognition, /R33 /required /substantial /assistance /with toileting and bed mobility, was occasionally incontinent of bladder and continent of bowel. R33 was at risk for a pressure ulcer, had no pressure ulcer/injury on admission.</p> <p>R33's diagnoses /included, cerebral /infarction-(CVA) (blood clot in the brain), pressure induced deep tissue damage of left /heel, /chronic systolic (congestive) heart failure /(a serious condition of the heart's ability to pump blood efficiently), edema (swelling).</p> <p>R33 was diagnosed with pressure induced deep tissue damage of left /heel (bedsore) on 2/19/26 and had an order for daily wound dressing change.</p> <p>R33 's after /visit note by /nurse practitioner (NP)-E /dated 2/19/26 Identified the following: Skin: left heel popped blister with purple color. DTI (deep tissue injury) and a large blister that has popped on left heel. Non weight bearing to left heel, wound care referral for left heel, cleanse wound with /vashe (wound cleanser), allow to dry, cover with /ABD pad /and wrap with kerlix.</p>	F0880		

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F0880 SS = E	<p>Continued from page 25</p> <p>R33's room or outside the room lacked EBP precautions. No signage on the door and no isolation cart (mobile container that stores personal protective equipment (PPE)- gowns, gloves, face shield, used by staff to prevent the spread of infection).</p> <p>During an interview on 2/25/26 at 9:40 a.m., DON and regional director of clinical services (RDCCS) indicated R33 was not to be on EBP. Indicated, EBP is only required for Chronic wounds, diabetic wounds, and Pressure Ulcers per the facility policy.</p> <p>The facility policy titled: Enhanced Barriere Precautions, reviewed on 3/28/24, indicates enhanced barrier precautions to be used for chronic wound care and defines chronic wound care as any skin opening requiring a dressing (excludes- shorter-lasting wounds, such as skin breaks or skin tears covered with adhesive bandage.</p>	F0880		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2026

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN:245254
Cycle Start Date: February 26, 2026

Dear Administrator:

On Cycle February 26, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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

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 **May 26, 2026** (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 **August 26, 2026** (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.

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD , HASTINGS, Minnesota, 55033	
(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
E0000	Initial Comments On 2/23/26-2/26/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.	E0000		03/18/2026
F0000	INITIAL COMMENTS On 2/23/26-2/26/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52546623C (iQIES #2650224). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 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.	F0000		03/26/2026
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F0583	R29, R54, and R57 were interviewed regarding their privacy preferences. Resident care plans were updated to reflect their preferences. On 03/23/2026, the Executive Director (ED) procured privacy curtains designated for use during contracted clinical services conducted in the day room. These curtains will be deployed to ensure visual privacy and maintain resident dignity during the provision of care	04/21/2026

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 reverse for further 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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F0583 SS = D	<p>Continued from page 1</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review the facility failed to ensure privacy was maintained during treatments for 3 of 3 residents (R29, R54, R57) reviewed for privacy.</p> <p>Findings include:</p> <p>During an observation on 2/23/26 at 1:19 p.m., R57 was in the facility day room receiving podiatry (foot)cares. R54 and R29 were in the day room waiting for their podiatry appointments. Upon completion of foot care, R57 was removed from room by the podiatry medical assistant (MA)-A. MA-A returned and moved R54 so his foot cares could be completed. R29 remained in the day room during R54's podiatry treatments. Once completed R54 was assisted out of the room by facility staff. MA-A then moved R29 so she could have her podiatry cares completed. During R29's podiatry treatment, nursing staff and cleaning staff were</p>	F0583	<p>Continued from page 1 in non-traditional treatment areas.</p> <p>On March 26, 2026, the Executive Director provided formal written notification to the contracted podiatry provider outlining the requirement to maintain resident privacy during services conducted in non-traditional treatment areas to ensure compliance with resident rights to privacy and confidentiality.</p> <p>To ensure continued compliance, clinical staff and contracted providers will receive education on the Resident Rights and Notification of Resident Rights Policy (POL_SS003) with completion scheduled for April 14, 2026. The DON or designee is responsible for the education.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	

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F0583 SS = D	<p>Continued from page 2 walking through the day room. Upon completion, R29 was taken back to her room by facility staff.</p> <p>R29's quarterly Minimum Data Set (MDS) assessment, dated 1/8/26, indicated R29 had severe cognitive impairment. Further, R29 was dependent on facility staff for all cares. R29's diagnosis included neurocognitive disorder with Lewy-bodies Dementia (progressive neurodegenerative disease caused by abnormal protein deposits that destroy brain cells), chronic pain syndrome, and cognitive communication deficit.</p> <p>During an interview on 2/23/26 at 4:48 p.m., family member (FM)-A stated R29 would not have wanted to have her podiatry treatment performed with other residents around to watch. FM-A stated she has a lot of pain in her feet and would have wanted to have her podiatry treatments in private.</p> <p>R54</p> <p>R54's quarterly MDS assessment, dated 11/12/25, indicated R54 had no cognitive impairment. Further, R54 was independent with ambulation, toileting, and hygiene. R54's diagnosis included cellulitis (bacterial infection) of left lower limb, cellulitis of right second toe, and amputation of right lesser toe.</p> <p>During an interview on 2/23/26 at 5:10 p.m., R54 stated he would prefer to have his podiatry treatments done in his room.</p> <p>R57</p> <p>R57's comprehensive MDS assessment, dated 11/26/25, indicated R57 had limited cognitive impairment. Further, R57 required a wheelchair for mobility, set-up assistance for hygiene/oral care, and was independent with eating. R57's diagnosis included prostate cancer, chronic kidney disease, and difficulty walking.</p> <p>During an interview on 2/23/26 at 5:57 p.m., R57 stated he would prefer to do his podiatry treatments in a private space.</p> <p>During an interview on 2/23/26 at 1:34 p.m., MA-A stated the podiatry team comes to the facility every 9 weeks. MA-A stated the services provided include callus shaving and nail clipping. Podiatry treatments are done in the day room, unless the residents are not able to get out of bed then the podiatrist will go to the residents room.</p> <p>During an interview on 2/23/26 1:41 p.m., medical</p>	F0583		

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F0583 SS = D	<p>Continued from page 3</p> <p>doctor (MD)-A stated he provided podiatry services roughly every 9 weeks. The services he provided were callus shaving and nail clipping, occasionally helping with ingrown toenails if this can be treated safely at the facility. When asked how treatments are handled in the clinic setting the MD-A stated the treatments would be done in a private room at his clinic. The facility staff bring in multiple residents at a time.</p> <p>During an interview on 2/25/26 9:19 a.m., director of nursing (DON), administrator, and regional director of clinical services (RDCS) confirmed medical procedures or treatments such as wound care, optometry, dental, or podiatry should be done in private. Administrator confirmed the podiatry treatments done on 2/23/26 were conducted in the day room. Further, stating multiple residents can be in the day room during podiatry treatments. DON and RDCS confirmed the importance of completing podiatry treatments in a private setting to ensure resident privacy.</p> <p>An undated facility policy titled Resident Rights and Notification of Resident Rights, the facility will ensure a residents right to privacy and confidentiality.</p>	F0583		
F0605 SS = D	<p>Right to be Free from Chemical Restraints</p> <p>CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e)</p> <p>§483.10(e) Respect and Dignity.</p> <p>The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any . . . chemical restraints</p> <p>imposed for purposes of discipline or convenience, and not required to treat the</p> <p>resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of</p> <p>resident property, and exploitation as defined in this subpart. This includes but is</p>	F0605	<p>R10 received an in-person, face to face evaluation with provider on February 26, 2026. The hospice case manager conducted a clinical review of the medication, and the PRN Haldol order was discontinued.</p> <p>To address residents potentially affected by this deficient practice, an immediate review of all residents receiving PRN antipsychotic medications was completed in collaboration with the attending providers and hospice partners. Any PRN antipsychotic orders lacking appropriate documentation, exceeding the 14-day limit, or without evidence of provider evaluation were promptly reviewed and either discontinued or updated to ensure compliance with facility policy.</p> <p>To ensure continued compliance, hospice providers and clinical staff received education on Psychotropic Medication Use Policy (POL_NS712) with completion scheduled for April 21, 2026. The DON or designee is responsible for the education.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	04/21/2026

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F0605 SS = D	<p>Continued from page 4 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must- . . .</p> <p>§483.12(a)(2) Ensure that the resident is free from chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. </p> <p>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.</p> <p>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>(1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>§483.45(e) Psychotropic Drugs. Based on a comprehensive</p>	F0605		

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F0605 SS = D	<p>Continued from page 5 assessment of a resident, the facility must ensure that--</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure an evaluation was completed prior to renewal of PRN (as needed) antipsychotic medications for 1 of 5 residents (R10) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R10's quarterly Minimum Data Set (MDS) assessment, dated 2/10/26 indicated R10 had severe cognitive impairment with a history of verbal behaviors. The MDS also indicated R10 was receiving hospice care and received antipsychotic medications (medications used to treat mental health disorders and behavioral</p>	F0605		

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F0605 SS = D	<p>Continued from page 6 disturbances).</p> <p>R10's diagnoses list included, unspecified dementia, cognitive communication deficit, anxiety, protein-calorie malnutrition.</p> <p>R10's care plan indicated mood state related to diagnosis of anxiety and restlessness and agitation, high risk medications including Haloperidol (antipsychotic medication), hospice services, and cognitive loss related to dementia.</p> <p>R10's medication administration record indicated R10 received haloperidol 1 mg every 4 hours PRN from 1/26-2/8 (21 doses given), haloperidol 1 mg every 1 hour 2/10-2/12 (4 doses given), and haloperidol 1 mg every hour 2/12-2/15 (8 doses given).</p> <p>R10's hospice enrollment history and physical signed by the hospice provider dated 1/19/26 indicated terminal illness attestation "based on my review of this patient's available medical record and discussion with the hospice admission nurse."</p> <p>R10's hospice orders dated 1/20/26 indicated a verbal order for haloperidol 0.5 mg every 4 hours as needed for confusion, restlessness, agitation, nausea with a hand written stop date of 2/2/26.</p> <p>R10's hospice orders dated 1/26/26 indicated a verbal order for haloperidol 1 mg by mouth every 4 hours as needed for agitation and hallucinations with a hand written stop date of 2/8.</p> <p>R10's hospice orders dated 2/10/26 indicated a verbal order for haloperidol 1mg every hour PRN agitation with a stop date 2/23/26.</p> <p>R10's medical record indicated R10 was seen by the facility provider on 1/8/26. R10's record indicated hospice provider last seen 1/20/26.</p> <p>During an interview on 2/25/26 at 2:34 p.m., licensed practical nurse (LPN)-A stated residents who receive as needed antipsychotic medications are seen by a provider every 14 days. LPN-A stated the facility has updated the hospice provider several times of the requirement residents must be seen face to face every 14 days when receiving an PRN antipsychotic medication. LPN-A verified, R10 was seen by the hospice provider on 1/20/26, the facility provider on 1/8/26, and an acute visit by the facility nurse practitioner on 2/19/26.</p> <p>During an interview on 2/26/26 at 8:36 a.m., the</p>	F0605		

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F0605 SS = D	<p>Continued from page 7 hospice registered nurse (HRN) stated R10 enrolled in hospice 1/20/26 and is seen weekly by nursing staff. HRN confirmed R10 is receiving scheduled and as needed haloperidol. She stated hospice manages the medication however it is the facility's responsibility to determine if the resident is having breakthrough issues. The haloperidol is ordered every two weeks based on a mutual discussion between herself, facility staff, and if needed, the hospice medical provider. Hospice providers are involved in the interdisciplinary meeting to recertify a resident every 90 days, however, do not begin seeing residents until after their second 90 day recertification. At that time, the hospice provider will see the resident face to face every 8 weeks. Hospice providers do not see the resident face to face to re-order as needed antipsychotic medications.</p> <p>During a joint interview on 2/26/26 at 10:54 a.m., with the facility director of nursing (DON) and the Regional Director of Clinical Services (RDCS), the DON stated PRN antipsychotic medications are "good for 14 days" and the facility will automatically put a stop date. The DON stated hospice is the one managing R10's PRN haloperidol and would be the ones to see R10 in person. The DON and RDCS reviewed R10's medical records and could not provide documentation R10 received a face-to-face visit by a provider every 14 days.</p> <p>A policy titled "Psychotropic Medication Use" dated 9/7/23 indicated parameters required for antipsychotic medications that included "PRN anti-psychotic orders are limited to 14 days and cannot be renewed unless the attending provider evaluates the resident for the appropriateness of that medication." It continued "Documentation will reflect implementation of the above" [referring to the list of required parameters].</p>	F0605		
F0656 SS = D	<p>Develop/Implement Comprehensive Care Plan</p> <p>CFR(s): 483.21(b)(1)(3)</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p>	F0656	<p>On February 24, 2026, the Interim Director of Nursing (DON) conducted a comprehensive review of the care plans for R24 and R33. Care plans were updated and revised as indicated to accurately reflect each resident's current condition, needs, and plan of care.</p> <p>A facility-wide audit of all resident care plans was initiated on Feb. 24, 2026 to ensure compliance with comprehensive care planning requirements.</p> <p>To ensure continued compliance, Nurse Managers, MDS Nurse, and staff nurses will be educated on the Comprehensive Assessments and Care Planning Policy (POL_NS101) with completion scheduled for April 21,</p>	04/21/2026

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F0656 SS = D	<p>Continued from page 8</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, observation and record review, the facility failed to develop a person-centered care plan for 2 of 2 residents (R24, R33) reviewed for care planning.</p> <p>Findings include:</p> <p>R33's Admission Minimum Data Set (MDS) assessment, dated 1/14/26, /indicated intact cognition. R33 /required /substantial /assistance /with toileting and bed mobility, was occasionally incontinent of bladder and continent of bowel. R33 was at risk for a pressure</p>	F0656	<p>Continued from page 8</p> <p>2026. The DON or designee is responsible for the education.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0656 SS = D	<p>Continued from page 9 ulcer, had no pressure ulcer/injury on admission. R33 had a pressure /reducing device for chair and bed.</p> <p>R33's diagnoses /included, cerebral /infarction (CVA) (blood clot in the brain), pressure induced deep tissue damage of left /heel, /chronic systolic (congestive) heart failure /(a serious condition of the heart's ability to pump blood efficiently), and edema (swelling).</p> <p>R33's admission /skin risk assessments, dated 1/8/26 indicated at risk for pressure ulcers with an intervention to reposition every two to three hours.</p> <p>R33's /care plan dated /1/12/26, /indicated R33 /needs /assistance with bed mobility, transfers, ambulation, and locomotion due to CVA. Interventions included assist /to turn and reposition.</p> <p>R33's record lacked the implementation of a care plan for risk of developing pressure ulcers and injuries.</p> <p>R33's mobility care plan dated 1/12/26, indicated R33 needs assist with bed mobility, transfers, ambulation, and locomotion due to CVA. Intervention dated 1/12/26, per skin care plan was to assist with turning and repositioning, although R33 care plan lacked a skin section care plan.</p> <p>R33's Care Sheet dated 02/24/26 lacked interventions to prevent developing pressure ulcers and injuries.</p> <p>During an interview with R33 on 2/24/26 at 4:05 p.m., R33 denied being assisted with frequent repositioning in bed and or chair.</p> <p>During an interview on 2/24/26 at 2:26 p.m., nursing assistant (NA)-B stated being unsure of R33 turning and reposition schedule. NA-B stated the schedule should be in point of care for charting and on the care sheet in a binder at the nursing station.</p> <p>During an interview on 2/25/26 at 8:34 a.m., director of nursing (DON) stated, there was no skin category or risk for pressure ulcer on R33's care plan.</p> <p>R24</p> <p>R24's quarterly Minimum Data Set (MDS) assessment dated 12/3/25, indicated R24 had no cognitive impairment. R24 required a walker for ambulation and was independent with eating, hygiene, and dressing. R24's diagnosis included COPD (progressive and irreversible lung disease causing shortness of breath), emphysema</p>	F0656		

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F0656 SS = D	<p>Continued from page 10 (progressive lung disease that causes damage to the air sacs in the lungs), and chronic respiratory failure with lack of oxygen.</p> <p>R24 record dated 2/13/26 was admitted to hospice.</p> <p>R24's comprehensive care plan lacked patient-centered hospice care plan.</p> <p>During an interview on 2/24/26 at 10:17 a.m., nursing assistant (NA)-A stated she is unsure why R24 was put on hospice. NA-A indicated there is a hospice binder although that includes just hospice numbers and miscellaneous. NA-A stated she was unsure what end-of life preferences R24 wanted.</p> <p>During an interview on 2/24/26 at 10:51 a.m., director of nursing (DON) and regional director of clinical services (RDCS) stated after the resident chooses a hospice company, the hospice banner is added in the electronic medical record (EMR), hospice contact information is added to the resident profile, and the resident care plan. The hospice care plan would include the hospice company information, hospice diagnosis, and any known resident choices and preferences. DON confirmed R24 was admitted to hospice on 2/13/26 and R24's care plan did not have a hospice care plan. DON and RDCS stated the hospice care plan is important, so all staff are aware of the resident status and how to care for them during the end-of-life stage.</p> <p>A facility policy titled Comprehensive Assessments and Care Planning dated 9/27/23, the facility will provide a comprehensive person-centered interdisciplinary care plan.</p>	F0656		
F0755 SS = D	<p>Pharmacy Srvcs/Procedures/Pharmacist/Records</p> <p>CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet</p>	F0755	<p>Physician orders for R1 and R54 were immediately reviewed on 02/26/2026 by the Director of Nursing (DON)/designee. The order was verified for accuracy, and medication availability in the ADU was confirmed. The resident was assessed for any adverse outcomes related to the delay, and no negative clinical impact was identified.</p> <p>All physician orders from the past 30 days were reviewed for all facility residents to ensure timely transcription and verification, medication availability, and absence of delays related to ADU dispensing or pharmacy delivery.</p> <p>To ensure continued compliance, education will be provided to licensed nurses and Health Unit</p>	04/21/2026

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F0755 SS = D	<p>Continued from page 11 the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 2 of 2 residents (R1, R54) reviewed for pharmacy services.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 12/9/25, indicated R1 was cognitively intact with no behaviors, have pressure reducing devices, nutritional supplementation, and dressings. R1 was independent with eating, set up for oral hygiene and required assistance for all activities of daily living.</p> <p>R1's care plan indicated R1 had wounds to both feet, impaired cardiac output, enhanced barrier precautions related to wounds, and diabetes,</p> <p>R1's diagnoses list included, cerebral palsy (brain disorder causing decreased muscle coordination) , peripheral vascular disease (disorder affecting circulation in the arms and legs), diabetes (disorder affecting blood sugar levels), respiratory failure (disorder affecting breathing), lymphedema (disorder causing fluid collection under the skin), and venous insufficiency(disorder that causes blood to pool in the legs instead of returning to the heart).</p> <p>R1's provider orders included:</p>	F0755	<p>Continued from page 11 Coordinators (HUCs) on order transcription and verification expectations, including: Orders must be entered and verified same day, or by next morning if received late, with completion scheduled for April 21, 2026. The DON or designee is responsible for the education.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	

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F0755 SS = D	<p>Continued from page 12 wound care: right dorsal [top] foot every other day and as needed (PRN)</p> <p>Sprinkle metronidazole [medication used to treat fungal infection] 500 mg crushed tablet into wound bed every other day.</p> <p>R1's medical record indicated the following:</p> <p>2/5/26-Wound Clinic provider wrote order for Metronidazole 500 mg to wound every other day</p> <p>2/6/26-health unit coordinator entered order into electronic medical record</p> <p>2/9/26-order was confirmed by facility nursing staff adding the location to apply metronidazole</p> <p>2/10/26-R1's medication administration record (MAR) indicated medication was not given with a progress note stating "Metronidazole currently unavailable. Writer left a message with pharmacy to see if this could be ordered."</p> <p>2/12/26-medication was signed off as given however facility progress note indicated "Metronidazole currently unavailable. Spoke with Rx (pharmacy), 30 day supply was delivered on 2/2 and 5 tablets were delivered on 2/5."</p> <p>2/16/26-MAR indicated metronidazole was not given</p> <p>2/17/26-facility progress note indicated "pharmacy to deliver metronidazole tonight for dressing changes to right foot."</p> <p>2/19/26-Wound nurse practitioner provider note indicated "metronidazole still hasn't come in or been applied. Nurse manager is going to look into Flagyl [metronidazole]"</p> <p>2/22/26-MAR indicated metronidazole was not given</p> <p>During an interview on 2/25/26 at 2:38 p.m., licensed practical nurse (LPN-A) confirmed R1 had chronic wounds to both feet that were followed by the wound clinic. LPN-A reviewed R1's MAR and confirmed dates metronidazole was not administered. LPN-A stated the medication should be in the automated dispensing unit (ADU) (machine used to dispense certain medications).</p> <p>During an interview on 2/25/26 at 3:31 p.m., the wound clinic nurse practitioner (NP)-B confirmed R1 had chronic wounds to both feet that are difficult to heal</p>	F0755		

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F0755 SS = D	<p>Continued from page 13 due to his diagnosis of venous insufficiency. NP-B stated she saw R1 for several months before referring R1 to the vascular clinic (clinic that treats circulatory issues). NP-B stated she started seeing R1 again "2-3 weeks ago". On 2/5 NP-B ordered metronidazole to R1's right foot due to a possible fungal infection. NP-B confirmed she saw R1 on 2/5, 2/12, and 2/19 and the metronidazole was not available at each visit. NP-B stated the medication "had to be reordered last week".</p> <p>During an interview on 2/25/26 at 4:00 p.m., licensed practical nurse (LPN)-B confirmed R1's treatment order included metronidazole 500 mg to right foot. LPN-B recalled 1 day the medication was not available and a message was left to the pharmacy to deliver. LPN-B stated the next day a supervisor told her the medication was located in the ADU.</p> <p>During observation and interview on 2/25/26 at 4:15 p.m., a tall locked cabinet was noted in the medication room. LPN-A stated staff log into the computer in order to dispense medications. A list of available medications was located on the front of the machine which included metronidazole 500 mg tablets.</p> <p>During interview on 2/26/26 at 9:15 a.m., LPN-C stated new orders received from the provider are given to the health unit coordinator to enter and then verified by a nurse the same day. If the order is received on the night shift, it will be verified the next morning. LPN-C stated if a medication is not available in the medication cart, she would see if the medication were available in the ADU. If it is not, she would update the nurse manager and let the provider know a dose was missed.</p> <p>During an interview on 2/26/26 at 11:07 a.m., the pharmacy tech (tech) stated if a medication isn't available in the ADU the pharmacy will send a separate bubble pack card to the facility containing the medication. If the ADU is out of medication, the facility must request it because the pharmacy is not automatically alerted. The tech stated they received the order for metronidazole for R1 on 2/9/26 however the original date is 2/6/26. The tech stated metronidazole was dispensed from the ADU on 2/14, 2/20, 2/22, and 2/23 and confirmed no metronidazole was dispensed from the machine from 2/9-2/13.</p> <p>A report received from the facility and the pharmacy confirms the dates of metronidazole was removed from the ADU.</p>	F0755		

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F0755 SS = D	<p>Continued from page 14</p> <p>During a joint interview with the director of nursing (DON) and Regional Director of Clinical Services (RDCS) on 2/26/26 at 11:18 a.m., the DON stated new orders are transcribed in the electronic medical record by either the health unit coordinator or a nurse and verified by a nurse. The DON stated she expects orders to be entered and verified the same day they are received. If an order is received late, she would expect it to be verified by the next morning. If a medication is not available, staff are expected to call the pharmacy, and update the provider. Some medications are available in the ADU or the e-kit (emergency kit). The DON and RDCS verified the order for metronidazole was dated 2/5/26 and entered on 2/6/26 by the HUC however was not verified until 2/9/26. The DON stated she would have expected the metronidazole order to be processed by the next day. The DCS stated some medications are automatically dispensed via the ADU and some are sent from the pharmacy in bubble packs. Night nurses obtain all scheduled medications from the ADU and disperse them in the appropriate medication carts for the following day. If a medication is not scheduled to be dispensed, nurses do have the ability to manually request the ADU to dispense a medication. The DON stated she was first made aware of the missing metronidazole on 2/19/26 and verified the medication was in the ADU. The DON stated she spoke to the pharmacy on 2/25/26 who stated the metronidazole was officially loaded to be dispensed on 2/12/26 however the machine didn't start automatically dispensing it until 2/20/26.</p> <p>A policy titled "Medication Ordering and Receiving From Pharmacy" dated 12/2017 did not reference the ADU machine.</p> <p>A policy regarding processing of provider orders was requested and not received.</p> <p>R54</p> <p>R54's quarterly Minimum Data Set (MDS) assessment dated 11/12/25, indicated R54 had no cognitive impairment. Further, R54 was independent with ambulation, toileting, and hygiene. R54's diagnosis included cellulitis (bacterial infection) of left lower limb, cellulitis of right second toe, and amputation of right lesser toe.</p> <p>R54's care plan for skin has issues related to left lower limb cellulitis, right foot amputation, and skin tears. Interventions included moisture barrier and creams to be used to protect skin.</p>	F0755		

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F0755 SS = D	<p>Continued from page 15 R54's record indicated the following:</p> <p>2/12/26 R54 was prescribed 25% urea lotion to both feet twice daily.</p> <p>2/12/26 at 10:14 p.m., progress note recognizing new prescription of 25% urea lotion, additionally from pharmacy: this is on over the counter (OTC) medication and pharmacy will not be providing it.</p> <p>2/19/26 at 2:23 p.m., progress note between pharmacy and facility, 25% urea lotion had been moved to the non-transcribed file at the pharmacy, facility requested immediate delivery of medication, additionally from pharmacy: they do not carry the specific percent of urea lotion-would need further clarification from ordering provider.</p> <p>2/21/26 at 10:09 p.m., progress note between pharmacy and facility, pharmacy only carries 20% or 40% urea lotion, please clarify with ordering provider. Message sent to triage to send new orders for urea cream.</p> <p>2/23/26 at 8:38 a.m., new order written for R54 for 20% urea cream to both feet twice per day.</p> <p>2/23/26 at 12:19 p.m., progress note, new orders received from triage for 20% urea cream to both feet twice per day. Order transcribed into electronic medical record (EMR).</p> <p>During observation on 2/23/26 at 1:19 p.m., R54 was observed in facility day room receiving podiatry cares. Medical doctor (MD)-A asked R54 if he had been using the urea lotion on his feet twice per day. R54 stated, he had not been using any lotion on his feet because the facility had not gotten the lotion yet. MD-A stated R54 needs the lotion to help reduce the dryness of his feet. R54 stated he didn't know when the facility would get the lotion.</p> <p>During a joint interview on 2/25/2026 at 2:08 p.m., director of nursing (DON), administrator, and regional director of clinical services (RDCS), DON stated new orders are typically ordered by the health unit coordinator (HUC) and a nurse verifies the orders. Further to this, orders should be completed and ready within 24 hours. RDCS stated the initial urea lotion order was received on 2/12/26 and confirmed there were issues with processing due to order clarification. DON stated the medication was reordered on 2/23/26 and was not available for use. DON stated it is important to obtain medications when ordered so residents can begin treatments as expected.</p>	F0755		

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F0755 SS = D	Continued from page 16 A facility policy titled Medication Ordering and Receiving from Pharmacy dated 12/17, medications and related products are received from the dispensing pharmacy on a timely basis.	F0755		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to monitor for effectiveness of a medication prescribed for sleep for 1 of 5 residents (R47) reviewed for unnecessary medications. Findings include: R47's Minimum Data Set (MDS) assessment, dated 12/2/25 identified R47 had no cognitive impairment, had lower extremity impairment on one side, maximum assistance with transfer and bed mobility, independent with toilet transfer, incontinent of bowel	F0757	On February 26, 2026, the Health Unit Coordinator (HUC) completed a review of sleep monitoring orders for R47. The order was updated as indicated to ensure accuracy, appropriateness, and alignment with the resident's current plan of care. A facility-wide audit was initiated on Feb. 26, 2026 of all residents with sleep monitoring orders to ensure orders are current, complete, and clearly defined. Any discrepancies were corrected immediately. To ensure continued compliance, Nurse Managers, floor nurses and HUC will receive education on sleep monitoring expectations, with completion scheduled for April 21, 2026. The DON or designee is responsible for the education. The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.	04/21/2026

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F0757 SS = D	Continued from page 17 and bladder. R47 diagnoses include polyneuropathy (a condition in which multiple peripheral nerves are damaged, leading to weakness, numbness and impaired function in various parts of the body), type 2 diabetes, major depressive disorder, anxiety, obstructive sleep apnea, and laceration to /right /great toe. R47's medication orders included: Melatonin tablet 5 milligram (mg), oral at bedtime: Start date 11/22/24. R47's Medication Administration Record (MAR) record review from 1/01/26 to 1/31/26 and 2/01/26 to 2/25/26 indicated medication was administered. R47's record lacked sleep tracking or monitoring assessment. During an interview on 2/26/2026 at 8:10 a.m., the director of nursing (DON) confirmed R47 taking melatonin 5 mg by mouth at bedtime for sleep. DON stated, sleep tracking was only initiated when ordered by the prescribing provider. DON also stated, sleep tracking would have been available in progress if it was ordered. Progress note review from 12/01/25 to 02/26/26 showed no sleep tracking notes. A facility policy on monitoring sleep was requested and not received.	F0757		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from	F0812	1. Corrective Action for Affected Areas All food boxes were immediately removed from the walk-in freezer floor and properly stored on shelving units at least six inches off the floor. The paper bowl used as a scoop was removed and discarded. The can opener (blade and gear) was removed, thoroughly cleaned, and sanitized. Culinary staff were immediately re-educated on proper sanitation procedures, appropriate utensil use, and food storage requirements. 2. Identification of Other Potentially Affected Areas All culinary staff received re-education on food safety and sanitation practices.	04/21/2026

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F0812 SS = F	<p>Continued from page 18 consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to clean and sanitize food-contact equipment, remove a paper bowl used as a scoop in a sugar container and keep food boxes off walk-in freezer unit floor.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 2/23/26 at 12:15 p.m., with the culinary director (CD), the following was identified: seven boxes were stored on the Walk-in freezer floor, a brown paper bowl used as scoop left in the sugar container and the can opener part that meets the top of the can (blade and gear) was covered with dark dry substance. CD confirmed the scoop in the sugar container, is not the usual practice indicated it could cause for cross contamination.</p> <p>During a follow up kitchen tour 2/25/26 at 7:52 a.m., the can opener blade and gear remained covered with the dark dry substance and additionally a red paste was noted on the blade. Head cook (HC) indicated it was used and must have gotten dirty yesterday.</p> <p>In the walk-in freezer, five food boxes remained on the floor. HC stated the boxes were not supposed to be on the floors and were delivered the day prior.</p> <p>During an interview on 2/25/26 at 8:46 a.m., CD stated, the expectation was for the can opener to be cleaned weekly, when asked about the substance covering the can opener blade and gear-can remove this. CD confirmed, (could remove this also) and the boxes in the walk-in freezer should not be on the floor.</p> <p>A facility policy on food safety procedures was requested and not received.</p>	F0812	<p>Continued from page 18</p> <p>A full kitchen audit was conducted, including review of all food-contact equipment, storage containers, scoop usage, and food storage practices.</p> <p>All storage areas, including delivery processes, were reviewed to ensure compliance with proper storage standards.</p> <p>3. Systemic Changes</p> <p>The daily cleaning task list was updated to include required daily cleaning and sanitizing of the can opener, with staff sign-off required each shift.</p> <p>The Food Safety and Sanitation Policy was reviewed, updated as needed, and redistributed to all culinary staff, with required acknowledgment of understanding.</p> <p>Staff were re-educated on proper scoop usage, including approved utensils and appropriate storage of scoops.</p> <p>Staff were re-educated on proper food storage practices, including maintaining all items at least six inches off the floor. This requirement has been added to daily and delivery checklists.</p> <p>4. Monitoring and Sustaining Compliance</p> <p>The Culinary Director or designee will conduct audits three (3) times per week for two (2) weeks, then two (2) times per week for two (2) weeks, followed by one (1) time per week for two (2) weeks.</p> <p>Audits will include review of equipment cleanliness, proper utensil usage, and food storage compliance.</p> <p>Any identified issues will be corrected immediately, with additional staff re-education as needed.</p> <p>Audit results will be reviewed through the facility's QAPI process to ensure ongoing compliance.</p>	
F0880 SS = E	<p>Infection Prevention & Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p>	F0880	<p>On February 25, 2026, immediate corrective action were taken to ensure proper infection control practices for R33, R57, and R66. No residents were identified as having adverse outcomes related to the deficient</p>	04/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD , HASTINGS, Minnesota, 55033	
(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
F0880 SS = E	<p>Continued from page 19 §483.80 Infection Control</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with</p>	F0880	<p>Continued from page 19 practice.</p> <p>A facility-wide review was conducted on February 25, 2026, of all residents on transmission-based or enhanced barrier precautions to ensure appropriate PPE signage was in place and available for staff adherence to required PPE use.</p> <p>To ensure continued compliance, all licensed nurses, CNAs, and ancillary staff (including therapy and contracted providers) will receive education on PPE requirements specific to COVID-19 isolation (Covid Policy Manual) and Enhanced Barrier Precautions (POL_IP060) with completion scheduled for April 14, 2026. The DON or designee is responsible for the education.</p> <p>Standardized MDH-approved PPE signage has been implemented facility-wide for all isolation rooms.</p> <p>The facility plans to monitor its adherence by completing random audits for five (5) residents weekly for four weeks, then monthly x 2 months. DON or designee is responsible for these audits. Audits will be reviewed at Quality Council (QC) meetings until substantial compliance has been determined by the QC team.</p>	

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F0880 SS = E	<p>Continued from page 20 residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to correctly establish and ensure staff followed appropriate transmission-based precaution (TBP) for 1 of 1 resident (R66) who required enhanced respiratory precautions for COVID-19. Further, the facility failed to ensure appropriate personal protective equipment (PPE) was used for residents in enhanced barrier precaution (EBP) during podiatry treatments in a common area for 1 of 3 residents (R57) reviewed for EBP. Additionally, the facility failed to initiate EBP for 1 of 1 resident (R33) who required EBP due to a pressure ulcer.</p> <p>Findings include:</p> <p>R66 was admitted to the facility on 2/20/26 from a hospital, her Minimum Data Set (MDS) assessment had not been completed at time of survey.</p> <p>R66's progress note dated 2/21/26 indicated R66 had severe cognitive impairment. R66 had a diagnosis of dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities) and Covid-19.</p> <p>According to the Centers for Disease Control (CDC), residents diagnosed with COVID-19 require additional</p>	F0880		

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F0880 SS = E	<p>Continued from page 21 TBP that included an isolation gown, N95 respirator or higher-level respirator, eye protection (goggles or face shield), and gloves.</p> <p>During observation on 2/24/26 at 10:52 a.m., physical therapy (PT)-A was observed entering R66's room with a standard mask (not an N95) and without an isolation gown or gloves, placed a gait belt in her room and exited room.</p> <p>During an interview on 2/24/26 at 11:08 p.m., PT-A stated he had only put on a standard mask (not an N95) when he returned the gait belt to the room he had used when working with R66. PT-A stated when returning the gait belt, he should have put on the appropriate PPE before entering the room that included the isolation gown, N95 mask, and gloves. PT-A stated it is important to wear the appropriate PPE every time you enter the room to prevent the spread of infection.</p> <p>During observation on 2/26/26 at 9:08 a.m., nursing assistant (NA)-C was delivering the meal tray to R66. NA-C put on an isolation gown, standard mask (not an N95), gloves, and eye protection. NA-C opened R66's door, walked inside room with meal tray and closed the door. At 2/26/26 at 9:11 a.m., NA-C exited R66's room, performed hand hygiene, then moved down hall to continue delivering meal trays.</p> <p>During an interview on 2/26/26 at 10:11 a.m., licensed practical nurse (LPN)-E stated they receive infection control education upon hire, annually, and if something changes. LPN-E stated the infection control education contains information about proper PPE for the different types of infections they see at the facility. LPN-E stated for a resident who was in isolation for COVID-19, the isolation required included an isolation gown, gloves, face mask, and an N95 mask. LPN-E stated staff should wear the appropriate PPE every time you enter the room of someone with COVID-19; this is important to prevent the spread of infection.</p> <p>During an interview on 2/26/26 at 10:17 a.m., NA-C stated staff receive education about infection prevention when they are hired, annually, and if something changes. NA-C stated the infection prevention education they received included how to apply and take off PPE, when to use PPE, and what type of PPE to use for the infections they typically see in the facility. NA-C stated the proper PPE to use when caring for someone with COVID-19 included an N95 mask, isolation gown, gloves, and goggles. NA-C stated she had been delivering morning meal trays that included R66. NA-C stated she was aware R66 had been diagnosed with</p>	F0880		

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F0880 SS = E	<p>Continued from page 22 COVID-19 and required additional PPE for that. NA-C confirmed she had not had a N95 mask on when delivering R66's meal tray. NA-C stated she did not wear the N95 mask because the isolation sign on the door stated she could wear an N95 mask or a standard mask. NA-C stated she thought residents with COVID-19 infections required an N95 mask but since the sign said she could wear a standard mask, that is why she wore the standard mask.</p> <p>During observation and interview on 2/26/26 at 10:28 a.m., director of nursing (DON) and regional director of clinical sales (RDCS) confirmed R66 had COVID-19; requiring additional PPE that would include an N95 mask, isolation gown, face mask, and gloves. RDCS confirmed staff are educated about isolation procedures when they are hired, yearly, and if there are any updates to isolation procedures. DON stated it is her expectation all staff at the facility should wear the appropriate PPE prior to entering R66's room. Additionally, DON and RDCS reviewed the isolation sign placed on R66's door, the isolation sign reflected staff would be required to wear:</p> <ul style="list-style-type: none"> -Gown -Facemask or -N95 Respirator for aerosol-generating procedures -Eye protection (goggles or face shield) -One pair of gloves -Hair cover (optional) <p>DON and RDCS confirmed the isolation sign currently on R66's door was not the correct sign; they were unsure where this sign came from or how it was placed on R66's door. RDCS stated the correct sign the facility uses read:</p> <ul style="list-style-type: none"> -Gown -N95 Respirator or higher-level respirator - Eye protection (goggles or face shield) -One pair of gloves <p>DON and RDCS stated it is important to apply the appropriate PPE to prevent the spread of infection. Additionally, the appropriate PPE should be worn every time facility staff enter R66's room.</p>	F0880		

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F0880 SS = E	<p>Continued from page 23</p> <p>R57</p> <p>R57's comprehensive MDS assessment, dated 11/26/25, indicated R57 had limited cognitive impairment . Further, R57 required a wheelchair for mobility, required set-up assistance for hygiene/oral care, and was independent with eating. R57's diagnosis included prostate cancer, chronic kidney disease requiring a urinary catheter (tube inserted into the body to drain urine), and difficulty walking.</p> <p>R57's care plan dated 11/11/24, had previously acquired infections and due to the placement of the urinary catheter, R57 now required EBP when receiving cares.</p> <p>During observation on 2/23/26 at 1:24 p.m., R57 was observed in the facility day room with 3 other residents; all 3 residents were receiving podiatry care. The podiatry team did not put on the appropriate PPE when providing treatment to R57; as recommended by the CDC. Medical doctor (MD)-A donned standard gloves removed R57's shoes and socks, performed callous shaving and clipping toenails. When completed, medical assistant (MA)-A assisted R57 with putting his shoes and socks back on; MA-A had not applied the appropriate PPE prior to assisting him.</p> <p>During an interview on 2/23/26 at 1:24 p.m., MA-A stated she was unsure if R57 required staff to wear special PPE when providing podiatry treatments. MA-A stated the podiatry team does not wear PPE when providing treatment, unless facility staff direct them to. MA-A stated she had not worn any additional PPE while caring for any of the residents today.</p> <p>During an interview on 2/23/26 at 1:41 p.m., MD-A stated he was unaware that R57 required podiatry staff to wear additional PPE when providing podiatry treatments. MD-A stated his team primarily performs callous removal and toenail clipping. MD-A stated he was aware of why residents would require additional PPE such as required for EBP; the primary reason being to reduce the spread of infection from one resident to another. When asked if residents in EBP or higher-level isolation should have podiatry treatments in a common area; MD-A stated only bed bound residents get podiatry care in their rooms. MD-A stated he would prefer the day room to be a private setting but, facility staff kept bringing more residents into the room.</p> <p>During an interview on 2/25/26 at 9:19 a.m., director of nursing (DON), regional director of clinical sales (RDCS), and administrator stated they would expect all</p>	F0880		

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F0880 SS = E	<p>Continued from page 24 ancillary service providers to adhere to the facility's infection prevention precautions such as EBP. The administrator confirmed he had walked through the day room during the podiatry treatments, PPE was not worn for residents receiving podiatry treatments. DON and RDCS stated it is important to apply the appropriate PPE to prevent the spread of infection. Additionally, the appropriate PPE should be worn every time facility staff or ancillary staff provide cares such as podiatry treatments.</p> <p>A facility policy titled COVID-19 Program Overview dated 9/29/22, healthcare workers caring for residents with suspected or confirmed COVID-19 should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator.)</p> <p>A facility policy titled Enhanced Barrier Precautions dated 4/1/24, residents with indwelling medical devices (such as a urinary catheter) require EBP when providing hygiene cares.</p> <p>R33</p> <p>R33's Admission Minimum Data Set (MDS) assessment, dated 1/14/26, /indicated, intact cognition, /R33 /required /substantial /assistance /with toileting and bed mobility, was occasionally incontinent of bladder and continent of bowel. R33 was at risk for a pressure ulcer, had no pressure ulcer/injury on admission.</p> <p>R33's diagnoses /included, cerebral /infarction-(CVA) (blood clot in the brain), pressure induced deep tissue damage of left /heel, /chronic systolic (congestive) heart failure /(a serious condition of the heart's ability to pump blood efficiently), edema (swelling).</p> <p>R33 was diagnosed with pressure induced deep tissue damage of left /heel (bedsore) on 2/19/26 and had an order for daily wound dressing change.</p> <p>R33 's after /visit note by /nurse practitioner (NP)-E /dated 2/19/26 Identified the following: Skin: left heel popped blister with purple color. DTI (deep tissue injury) and a large blister that has popped on left heel. Non weight bearing to left heel, wound care referral for left heel, cleanse wound with /vashe (wound cleanser), allow to dry, cover with /ABD pad /and wrap with kerlix.</p>	F0880		

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F0880 SS = E	<p>Continued from page 25</p> <p>R33's room or outside the room lacked EBP precautions. No signage on the door and no isolation cart (mobile container that stores personal protective equipment (PPE)- gowns, gloves, face shield, used by staff to prevent the spread of infection).</p> <p>During an interview on 2/25/26 at 9:40 a.m., DON and regional director of clinical services (RDCS) indicated R33 was not to be on EBP. Indicated, EBP is only required for Chronic wounds, diabetic wounds, and Pressure Ulcers per the facility policy.</p> <p>The facility policy titled: Enhanced Barriere Precautions, reviewed on 3/28/24, indicates enhanced barrier precautions to be used for chronic wound care and defines chronic wound care as any skin opening requiring a dressing (excludes- shorter-lasting wounds, such as skin breaks or skin tears covered with adhesive bandage.</p>	F0880		

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K0000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety Code survey was conducted on 02/24/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Regina Senior Living 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.</p> <p>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.</p> <p>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.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> <p>Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR</p> <p>By email to:</p>	K0000		03/26/2026
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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 reverse for further 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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K0000	<p>Continued from page 1</p> <p>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 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. <p>Building Info:</p> <p>REGINA SENIOR LIVING is a 1 story building with full basement.</p> <p>The original building was constructed at 2 different times. The original building, 1 story with basement, was constructed in 1965 and was determined to be of Type II (111) construction. In 2012, a 1 story addition (TCU) was constructed and was determined to be of Type II (111) construction.</p> <p>Because the original building and addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type II (111).</p> <p>The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification.</p> <p>The facility has a capacity of 57 beds and had a census of 46 at the time of the survey.</p>	K0000		

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K0000	Continued from page 2	K0000		
K0363 SS = E	<p>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:</p> <p>Corridor - Doors</p> <p>CFR(s): NFPA 101</p> <p>Corridor - Doors</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 19.3.6.3.5. This deficient finding could have a patterned impact on the residents within the facility.</p>	K0363	<p>Corridor –Doors is in our TELS work order system and has been moved from an annual inspection to a Bi-Annual inspection.</p> <p>The EVS Director and or trained maintenance staff will ensure all corridor doors are inspected according to the TELS schedule.</p> <p>The door observed to be out of compliance was corrected the day of the survey.</p> <p>Audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then bi-annual TELS inspections. All results will be reviewed by the quality council.</p>	04/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD , HASTINGS, Minnesota, 55033	
(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
K0363 SS = E	Continued from page 3 On 02/24/2026 at 11:19 AM, it was revealed by observation that the door to the soiled linen room in the basement could not positively latch. This deficiency was corrected at the time of the survey An interview with the EVS Director and Executive Director verified these deficient findings at the time of discovery.	K0363		
K0372 SS = E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. On 02/24/2026 at 10:50 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors in the TCU, caused by an electrical box. This deficiency was corrected at the time of the survey. An interview with the Executive Director and EVS Director verified this deficient finding at the time of discovery.	K0372	Smoke barriers will be checked for any penetrations requiring repairs at the time of inspection. Smoke barriers will inspected by the EVS Director and or trained maintenance staff on a bi-annual basis or when any contractor work is preformed in the immediate area and entered into TELS our preventative Maintenance program. The smoke barrier that was found to be out of compliance was corrected the day of survey. Audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then bi-annual + after any contractor work. All results will be reviewed by the quality council.	04/21/2026
K0521 SS = F	HVAC	K0521	The smoke dampers that were found not in compliance during the survey are entered in TELS our maintenance	04/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER REGINA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 NININGER ROAD , HASTINGS, Minnesota, 55033	
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K0521 SS = F Bldg. 01	Continued from page 4 CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. On 02/24/2026 at 10:15 AM, it was revealed by a review of available documentation that the facility could not provide a current fire damper inspection report for an inspection that would have occurred in the last 4 years. The last inspection was completed on 5/27/2021 An interview with the EVS Director verified this deficient finding at the time of discovery	K0521	Continued from page 4 system as an every 4 year inspection per NFPA 101 (2012 edition). The EVS Director will facilitate and schedule the necessary inspections with a qualified contractor. The inspection of the smoke dampers is scheduled for the week of March 23rd 2026 with Nasseff and reports will be kept in the Life Safety Survey Book. Track in TELS per 4-year NFPA requirement. Annual verification audit of documentation and reviewed by quality council.	