Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 26, 2026

Administrator
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS
2501 RICE LAKE ROAD
DULUTH, MN 55811

RE: CCN:245366
Cycle Start Date: March 12, 2026

Dear Administrator:

On March 12, 2026, a survey was completed at your facility by the Minnesota Department(s) 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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 12, 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 September 12, 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.

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Re: State Nursing Home Licensing Orders
Event ID: 1E3E54-H1

Dear Administrator:

The above facility survey was completed on March 12, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245366	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD , DULUTH, Minnesota, 55811

(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 3/9/26-3/12/26, 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		04/01/2026
F0000	INITIAL COMMENTS On 3/9/26-3/12/26, a standard recertification survey was conducted at your facility. Complaint investigations were 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: H53667882C (2738091), H53667884C (2687795), H53667885C (2681119), H53667886C (2672774), H53667887C (2600886), without citations. The following complaint was reviewed: H53667883C (2699210) with a citation at F684. 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		04/01/2026
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.	F0605	Completion Date: 4/8/2026 F605 Right to be Free from Chemical Restraints	04/08/2026

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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F0605 SS = D	Continued from page 1 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 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §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: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.	F0605	Continued from page 1 SS=D The facility failed to ensure psychotropic medication PRN orders had end date for use for 1 of 5 residents (R83) reviewed for unnecessary medications. Corrective Action Resident 83 is no longer ordered PRN Olanzapine. Identifying other residents Residents currently residing in the facility with orders for PRN antipsychotic medication have the potential to be affected. Current residents' medication list was reviewed for PRN antipsychotic medications to ensure face-to-face visits occurred or end date to meet CMS regulations. Systemic Changes IDT will be educated on F605 prior to start of next shift. Nurses will be educated on F605 prior to start of next shift. Pharmacy consultant will audit medication orders during monthly reviews to ensure all medication orders have an appropriate end date and/or face to face visits. Unnecessary Drugs-Psychotropic Drugs policy was reviewed and remains appropriate. Monitoring DON/designee shall audit PRN psychotropic medications to ensure all medication orders have an appropriate end date or face to face visit for use. Daily x 7 days then 10 medication orders weekly x 3 weeks then monthly x 3 months or until sustained compliance is achieved.	

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F0605 SS = D	Continued from page 2 §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- (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. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §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; §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; §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 §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.	F0605	Continued from page 2 Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F0605 SS = D	Continued from page 3 §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. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a resident prescribed an as needed (PRN) antipsychotic (AP) medication received a face-to-face visit with the provider before re-ordering the medication and failed to have documentation to support PRN AP medication use for 1 of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83's quarterly minimum data set (MDS) dated 1/19/26, identified intact cognition and diagnoses of dysthymic disorder, anxiety, adjustment insomnia, and delusional disorder. Section N identified R83 took an AP medication. R83's care plan …. Mood/behavior - observe/monitor/document behaviors/m ood and notify supervisor, SW and/or MD as needed, psych services as ordered, at risk for agitation and reassure and reapproach as needed. Risk for noncompliance. R83's electronic medical record (EMR) identified the following in 2026: 1/10, an order for olanzapine (an atypical antipsychotic medication) 5 mg tablet by mouth PRN one time a day for agitation or anxiety for 14 days, discontinue on 1/23/26. 1/11, a medication administration record (MAR) entry for PRN olanzapine 5 mg. 1/13, a MAR entry for PRN olanzapine 5 mg. 1/21, a MAR entry for PRN olanzapine 5 mg. 1/23, an order for olanzapine 5 mg tablet by mouth PRN one time a day for agitation or anxiety for 14 days, discontinue on 2/26/26. 1/27, a MAR entry for PRN olanzapine 5 mg. 2/26, an order for olanzapine 5 mg tablet by mouth PRN one time a day, discontinue on 3/2.	F0605		

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F0605 SS = D	Continued from page 4 2/26, a MAR entry for PRN olanzapine 5 mg. 3/2, an order for olanzapine 5 mg tablet by mouth PRN one time a day for agitation or anxiety, discontinue on 3/12. 3/4, a MAR entry for PRN olanzapine 5 mg. Evidence of correlating behavior documentation and face-to-face provider visits weren't found in R83's EMR. During an interview on 3/12/26 at 12:11 p.m., RN-E, a nurse manager, would expect an order to be discontinued after 14 days if that is what the order was for, and stated she wasn't sure what happened. RN-E stated her expectation was for behavior charting to be done every shift and when using a PRN AP medication. During an interview on 3/12/26 at 2:59 p.m., pharmacy consultant (PC)-G would have expected the order to stop after 14 days, and for the provider to see the resident face to face if renewing an as-needed antipsychotic. A policy, Unnecessary Drugs-Psychotropic Drugs dated 2/27/23, identified 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. PRN orders for psychotropic medications will be limited to 14 days unless the physician identifies the rationale to extend the medication beyond 14 days. PRN antipsychotic drugs will be limited to 14 days and will not be renewed unless the physician evaluates the resident for appropriateness of the medication. The provider should determine and document the following:Is the antipsychotic medication still needed on a PRN basis?What is the benefit of the medication to the resident?Have the resident's expressions or indications of distress improved as a result of the PRN medication?	F0605		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F0610	Completion Date: 4/8/2026 F610 Investigate/Prevent/Correct Alleged Violation SS=D The facility failed to investigate an accident that resulted in injuries for 1 of 8 residents (R106) reviewed for accidents.	04/08/2026

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F0610 SS = D	Continued from page 5 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to investigate an accident that resulted in injuries for 1 of 8 residents (R106) reviewed for accidents. Findings include: R106's quarterly Minimum Data Set dated 1/8/26, identified R106 had diagnoses which included disease of spinal cord, dementia, diabetes mellitus, paranoid schizophrenia, insomnia, nicotine dependence, tobacco use, and repeated falls. In addition, R106's MDS identified he was moderately cognitively intact. R106's current care plan report identified he was at risk for falls. Interventions included the following: Call light positioned for easy access initiated on 4/10/25 Fall Review per facility protocol initiated on 4/10/25 Have commonly used articles within easy reach initiated on 4/10/25 Wheelchair-anti-rollbacks initiated on 5/19/25 Call don't fall sign placed initiated on 5/19/25 R106's care plan report identified R106 smoked. Interventions included the following: Assess for safe smoking practice upon admission, quarterly, and as needed initiated on 4/10/25 Educate/remind of the facility smoking policy as needed. Has agreed to follow the policy initiated on 4/10/25	F0610	Continued from page 5 Corrective Action Resident 106 new smoking and fall assessments completed. Resident 106 care plan was updated. Identifying other residents Current Residents with falls have the potential to be affected. Residents who smoke have the potential to be affected. Systemic Changes IDT will be educated on F610 prior to start of next shift. Nurses will be educated on F610 prior to start of next shift. Smoking Policy Revised Falls/Accident policy reviewed and remains appropriate. Incident Investigation policy was reviewed and remains appropriate. Monitoring DON/designee shall audit Risk Management reports related to falls ensuring root cause analysis completed. Daily x 7 days, then weekly x 3 weeks, then Monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD , DULUTH, Minnesota, 55811

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F0610 SS = D	Continued from page 6 Smoking material will be stored in locked drawer in room or designated safe area for example on person or in a pocket initiated on 4/10/25 The facility smoking list provided on 3/9/26, listed R106 as a current smoker. The facility's investigation of R106's fall on 1/26/26, identified the following: The date the incident occurred, the location, R106's description of the incident (he was unable to say how he fell), immediate actions taken (lifted off of the ground with an assist of two, brought inside, nasal bleeding stopped, sent to the emergency department for evaluation). The explanation was "Fell off his w/c (wheelchair) outside in the smoking area. Unable to explain incident." No statements gathered, no further notes on follow-up, no root cause analysis, no changes made to R106's care plan. During an interview on 3/11/26 at 2:36 p.m., registered nurse (RN)-D stated he was unsure if a root cause analysis had been completed after R106's fall. He stated they did not complete a smoking assessment after the fall citing the resident's power of attorney no longer wanted R106 to smoke. During an interview on 3/12/26 at 11:36 p.m., the director of nursing (DON) verified that a thorough investigation of R106's fall had not been documented. The DON stated there was not any education completed for staff on falls, smoking, or smoking during inclement weather. The DON stated it was important to complete a root cause analysis to figure out why the incident occurred, and to prevent reoccurrence. The facility's root cause analysis of the incident was requested but not provided. Incident Investigation Procedure dated 2/8/24, identified, "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator." The policy identified any corrective action would be documented and other pertinent data as necessary or required. The policy further identified, "Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities."	F0610		
F0628 SS = D	Discharge Process	F0628	Completion Date: 4/8/2026	04/08/2026

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F0628 SS = D	Continued from page 7 CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F0628	Continued from page 7 F628 Discharge Process SS=D The facility failed to meet the requirements for a bed hold notification, including having it in writing and including contact information for the area office of ombudsman for long term care, for 1 of 2 residents (R51) reviewed for hospitalization. Corrective Action Resident 51 is no longer a resident at this facility. Identifying other residents Residents currently residing in the facility and transferred out of facility have the potential to be affected. Systemic Changes IDT educated on Bed Hold Policy RN and LPN educated on Bed Hold Policy Bed Hold Policy reviewed and remains current. Monitoring DON/designee shall audit hospital discharges to ensure Bed Hold Notifications have been provided to resident/POA and documented on EMR daily x 5 days, then weekly x 3 weeks, then monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F0628 SS = D	Continued from page 8 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone	F0628		

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F0628 SS = D	Continued from page 9 number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F0628		

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F0628 SS = D	Continued from page 10 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to meet the requirements for a bed hold notification, including having it in writing and including contact information for the area office of ombudsman for long term care, for 1 of 2 residents (R51) reviewed for hospitalization. Findings include: R51’s annual minimum data set (MDS) dated 2/13/26,	F0628		

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F0628 SS = D	Continued from page 11 identified intact cognition and a diagnosis of chronic pulmonary edema. R51's electronic medical record (EMR) identified R51 was transferred to the hospital on 3/7/26 at 11:26 p.m. A progress note identified a resident transfer charting template which included the reason for the transfer and other questions where the writer could enter in the text. There was an affirmative response to the question "does resident or power of attorney (POA) want a bed hold?". During an interview on 3/11/26 at 11:56 a.m., registered nurse (RN)-F stated bed holds were done on a form, and they would ask the resident if they wanted a bed hold but wasn't sure what the current process was because they were trying to get rid of paper, but he could find out. During an interview on 3/11/26 at 12:00 p.m., RN-B stated they would make note of whether the resident wanted a bed hold. RN-B thought there was a form the resident would sign and probably get uploaded to the chart. During an interview on 3/11/26 at 1:04 p.m., the director of nursing (DON) demonstrated the template used in the electronic medical record (EMR) when residents were transferred out of the facility indicating if they wanted a bed hold or not. The DON added they had just changed to this process, but they did go over bed hold information with residents on admit and annually. A policy, Bed Holds dated 9/8/24, identified the resident or responsible party must be notified concerning the bed hold policy of Hilltop Healthcare and sign the policy as evidence that they have been properly notified prior to being charged for any service. A copy of this policy will be sent with the resident when transferred to the hospital. At the time of transfer or therapeutic leave, staff will provide the current resident/responsible party with a copy of the policy. In case of emergency transfer, staff will attempt to provide the resident with a copy and will notify the responsible party of the transfer and policy within twenty-four (24) hours. Staff will follow up with a phone call to clarify any questions concerning the policy on the next working business day.	F0628		
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j)	F0641		04/08/2026

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F0641 SS = A	Continued from page 12 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to accurately code the minimum data set (MDS) for 1 of 2 residents (R6) reviewed for the Preadmission Screening and Resident Review (PASRR) process. Findings include: The PASRR process is a critical component of Medicaid's long-term care program, ensuring that individuals with serious mental illness and/or intellectual disability are not placed inappropriately in nursing facilities. It involves a series of screenings and evaluations to determine the appropriate setting for the individual, whether it be in the community, a nursing facility, or	F0641		

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F0641 SS = A	Continued from page 13 acute care settings. R6's annual MDS dated 11/3/25, identified intact cognition and diagnoses of anxiety, depression, and psychotic disorder. Section A identified R6 wasn't considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. A document, Level II Preadmission Screening (PAS) for Persons with Mental Illness Determination for Nursing Facility Admission dated 5/16/25, identified R6 had a mental health diagnosis of obsessive-compulsive disorder (OCD) and would need mental health services while at the nursing facility. During an interview on 3/11/26 at 2:26 p.m., the assistant director of nursing (ADON) identified they completed R6's 11/3/25 MDS and that Section A should have identified "yes" to the serious mental health condition, R6 had a PASRR level two. The ADON stated she would amend this MDS.	F0641		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F0657	Completion Date: 4/8/2026 F657 Care Plan Timing and Revision SS=D The facility failed to update a resident's care plan, including the resident's inability to safely smoke after a fall from wheelchair while smoking, for 1 of 1 resident (R106) reviewed for accidents. Corrective Action Resident #106 New Smoking and Fall Assessment completed. Resident #106 Smoking and fall care plans were updated and revised. Identifying other residents Current Residents with fall incidents have the potential to be affected. All residents who smoke care plans were audited and revised if necessary.	04/08/2026

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F0657 SS = D	Continued from page 14 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to update a resident's care plan, including the resident's inability to safely smoke after a fall from wheelchair while smoking, for 1 of 1 resident (R106) reviewed for accidents. Findings include: R106's quarterly Minimum Data Set dated 1/8/26, identified R106 had diagnoses which included disease of spinal cord, dementia, diabetes mellitus, paranoid schizophrenia, insomnia, nicotine dependence, tobacco use, and repeated falls. In addition, R106's MDS identified he was moderately cognitively intact. R106's current care plan report identified he was at risk for falls. Interventions included the following: Call light positioned for easy access initiated on 4/10/25 Fall Review per facility protocol initiated on 4/10/25 Have commonly used articles within easy reach initiated on 4/10/25 Wheelchair-anti-rollbacks initiated on 5/19/25 Call don't fall sign placed initiated on 5/19/25 R106's care plan report identified R106 smoked. Interventions included the following: Assess for safe smoking practice upon admission, quarterly, and as needed initiated on 4/10/25 Educate/remind of the facility smoking policy as needed. Has agreed to follow the policy initiated on 4/10/25 Smoking material will be stored in locked drawer in room or designated safe area for example on person or in a pocket initiated on 4/10/25 The facility smoking list provided on 3/9/26, listed	F0657	Continued from page 14 Systemic Changes Education to IDT regarding F657 Care Plan Timing and Revision to include: Incident/Accident documentation Updating Care Plans (New care plan revision procedure) Education to nursing staff regarding F657 Care Plan Timing and Revision to include: Incident/Accident documentation Updating Care Plans (New care plan revision procedure) Incident Investigation Procedure was reviewed and remains appropriate. Care Plan Revision Procedure created Monitoring DON/designee shall audit Risk Management reports to ensure care plans have been updated/revised to address the root cause of fall incidents daily x 7 days, then weekly x 3 weeks, then monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F0657 SS = D	Continued from page 15 R106 as a current smoker. The facility's investigation of R106's fall on 1/26/26, identified the following: The date the incident occurred, the location, R106's description of the incident (he was unable), immediate actions taken (lifted off of the ground with an assist of two, brought inside, nasal bleeding stopped, sent to the emergency department for evaluation). The explanation was "Fell off his w/c (wheelchair) outside in the smoking area. Unable to explain incident." No statements gathered, no further notes on follow-up, no root cause analysis, no changes made to R106's care plan. During an interview on 3/11/26 at 2:36 p.m., registered nurse (RN)-D recalled the incident when R106 fell. RN-D was unsure if R106's care plan had been updated but did state his power of attorney no longer wanted R106 to smoke, RN-D reviewed the care plan and verified it had not been updated. During an interview on 3/12/26 at 11:36 a.m., the director of nursing (DON) verified there were no updates made to the resident's care plan after the incident. Incident Investigation Procedure dated 2/8/24, identified, "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator." The policy identified any corrective action would be documented and other pertinent data as necessary or required. The policy further identified, "Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities."	F0657		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F0684	Completion Date: 4/8/2026 F684 Quality of Care SS=D The facility failed to monitor weights to identify possible congestive heart failure (CHF) exacerbation for 1 of 1 resident (R119) reviewed for quality of care Corrective Action	04/08/2026

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F0684 SS = D	Continued from page 16 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to monitor weights to identify possible congestive heart failure (CHF) exacerbation for 1 of 1 resident (R119) reviewed for quality of care. Findings include: R119's entry Minimum Data Set (MDS) dated 3/6/26, identified R119's cognition had not been assessed. R119's diagnoses included acute on chronic CHF, acute resp failure with hypercapnia, diabetes mellitus type 2 (DM2), hypertension (HTN), morbid obesity, and obstructive sleep apnea (OSA). R119's 48-hour Care Plan (paper document) dated 3/6/26 indicated R119 is cognitively intact with admission diagnoses of acute diastolic heart failure and obesity. R119's care plan dated 3/12/26, instructed:Record weights a minimum of monthly or per MD/RDN.R119's provider orders dated 3/12/26 included:Daily weight one time a day related to acute diastolic (congestive) heart failure, ordered 3/9/26.Elevate legs and prevent extended periods where legs are down, every dayshift for lower extremity edema management.Bumetanide Oral Tablet 2 MG (Bumetanide) Give 1 tablet by mouth at bedtime related to acute on chronic diastolic (congestive) heart failure.Spironolactone Oral Tablet 25 MG (Spironolactone) Give 1 tablet by mouth one time a day related to acute on chronic diastolic (congestive) heart failure.R119's treatment administration record (TAR) dated 3/12/26, instructed staff to obtain a daily weight one time a day related to CHF, with order dated 3/9/26 at 12:51 p.m. R119's Admission/Readmission Tool dated 3/6/26 at 2:50 p.m., identified a most recent weight of 327.0 dated 9/23/25 while other most recent vitals were dated 3/6/26. Review of R119's weight record dated 3/12/26, identified an admission weight dated 3/6/26, a struck-out weight dated 3/10/26, and two weights on 3/11/26 (at 10:14 a.m. and 5:40 p.m.). This record was also reviewed on 3/9/26 and no weights were entered at that time. R119's nurse progress notes for 3/2026 were requested but not received. During an observation on 3/9/26 at 1:05 p.m., R119 was	F0684	Continued from page 16 Resident #119 weight order is being completed and documented daily as ordered by provider and/or documented appropriately for refusals/notifications. Identifying other residents Current Residents with CHF diagnosis and/or Daily Weights orders have the potential to be affected. All residents with CHF diagnosis, request orders for weight frequencies. Systemic Changes IDT will be educated on the following: Daily Weights and documentation CHF Standing Orders for Skilled Nursing Licensed Nurses will be educated on the following: Daily Weights and documentation CHF Standing Orders for Skilled Nursing DON/Designee will review new admissions to identify CHF diagnosis and orders for Daily Weights are entered. Monitoring DON/designee shall audit Daily weights to ensure orders are entered, completed and documented daily x 7 days, then weekly x 3 weeks, then monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245366	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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F0684 SS = D	Continued from page 17 in their wheelchair in their room. They asked registered nurse (RN)-C to assist with elevating their legs on the bed. RN-C assisted with positioning bilateral legs on bed. R119 stated his physician wanted him to elevate his legs often to reduce swelling. During an interview on 3/11/26 at 3:39 p.m., RN-B stated staff obtain a weight on admission, residents with CHF would be weighed daily, and all residents were weighed weekly on their shower day. They stated the nurse enters the standing order when a resident with CHF is admitted. They confirmed their concern that weight gain in a CHF resident could be a sign of fluid retention, which could lead to breathing issues and the need for diuresis. RN-B stated they identified on 3/9/26 that R119 had no order for daily weights and entered the standing order. Reviewing R119's weight record, they confirmed that no admission weight was entered and R119 had a recorded weight gain of 19.1 pounds in one day (338.3 pounds on 3/10/26 to 357.4 pounds on 3/11/26). RN-B stated they were present at R119's admission, requested a mechanical lift weight, and observed it being done. During an interview on 3/12/26 at 10:11 a.m., RN-C stated vitals, including weight, would be taken immediately on admission. They stated the standing order was daily weights for three days then weekly unless there was a specific order for a resident with CHF or dietary concerns which required continuing daily weights. They confirmed they would be concerned for significant weight change in a resident with CHF. RN-C stated if there was a weight change, they would reweigh the resident and notify the physician of a significant change. During an interview on 3/12/26 at 10:15 a.m., RN-B stated they found R119's admission weight on the admission nurse's handwritten notes. RN-B stated they entered the weight historically in R119's medical record. RN-B stated the nurse that entered R119's weight on 3/10/26 thought it was entered incorrectly so RN-B struck the weight from R119's record. During an interview on 3/12/26 at 10:24 a.m., director of nursing (DON) stated vitals, including weight would be taken on resident admission, then daily weight for three days to establish a baseline, and then weekly unless the resident has CHF or malnutrition diagnoses, which may require more frequent monitoring. The DON stated if there is a weight discrepancy, the electronic medical record would flag it in red, and they expected staff to reweigh the resident for accuracy, complete an assessment, and update the provider. The facility	F0684		

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F0684 SS = D	Continued from page 18 parameters for significant weight loss was more than 2 pounds overnight or 5 pounds in a week. With weight gain in CHF residents, the DON was concerned for fluid retention, shortness of breath, edema, and CHF exacerbation. Review of undated facility document of hand-written nurse notes indicated R119's admission weight was 352.8. The facility document Standing Orders for Skilled Nursing Facilities signed and dated 6/13/25, in admission to facility, indicated daily weights for residents with heart failure unless otherwise directed.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed to prevent potential aspiration for 1 of 9 residents (R99) reviewed for accidents. Findings include: R99's Medicare 5 day Minimum Data Set (MDS) dated 2/26/26, identified R99 had diagnoses which included enterocolitis due to clostridium difficile recurrent (a severe infection causing inflammation of the colon [large intestine]), retention of urine, pressure ulcer, dysphagia (difficulty swallowing), and long term use of opiate (a type of medication that acts on the central nervous system to reduce pain, cause sleep, or induce feeling of euphoria). R99's MDS identified she required set up for meals. R99's Order summary identified R99 has orders for a cardiac mechanical soft texture, regular/think consistency dated 3/4/26.	F0689	Completion Date: 4/8/2026 F689 Free of Accident Hazards/Supervision/Devices SS=D The facility failed to ensure the care plan was followed to prevent potential aspiration for 1 of 9 residents (R99) reviewed for accidents. Corrective Action Resident #99 is encouraged to get out of bed for meals or head of bed is raised to 90 degrees to prevent aspiration. Identifying other residents Current residents with aspiration risk have the potential to be affected. Systemic Changes IDT will be educated on Dysphagia protocol and Following Care Plan Interventions. All nursing staff will be educated on Dysphagia protocol and Following Care Plan Interventions. Kardex – ADL Procedure reviewed and remains current.	04/08/2026

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F0689 SS = D	Continued from page 19 R99's care plan dated 2/13/26, identified R99 had actual complications with deficits with activities of daily living related to current medical/physical status. Interventions included eating; set up, ensure resident is up in wheelchair for all meals, encourage to eat in the dining room, upright at 90 degrees for oral intake and for 30 minutes afterwards. R39's swallow evaluation dated 2/24/26, identified strategies recommended by speech therapy were to have the resident alternate liquids and solids, general swallow techniques/precautions and bolus size modifications and have an upright posture during meals and for greater than 30 minutes after meals. During an observation on 3/11/26 at 8:28 a.m., room trays were being passed to residents who were eating in their rooms. R99 received her breakfast in her bed. -at 8:34 a.m., R99 was seated in her bed. The bed was elevated to about 45 degrees as she was eating her breakfast. -at 8:49 a.m., R99 remained in bed. Both hands were under the covers; she was still at about 45 degrees her tray remained on the overbed table in front of her. -at 1:22 p.m., R99 was observed in bed eating lunch. Her bed was at about 45 degrees. During an interview on 3/11/26 at 1:24 p.m., registered nurse (RN)-B looked in R99's room and verified the bed was elevated at about 45 degrees. RN-B stated the bed should be at 90 degrees when R99 declined to get out of bed and come to the dining room for her meals. RN-B stated the head of the bed at 90 degrees was important to prevent choking. A policy on dysphagia was requested but not provided.	F0689	Continued from page 19 Monitoring DON/designee shall perform observation audits for residents identified as aspiration risk/supervision to ensure care plan interventions are followed while eating daily x 7 days, then weekly x 3 weeks, then monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F0732	Completion Date: 4/3/2026 F732 Posted Nurse Staffing Information SS=C The facility failed to ensure the required nurse staffing information included the required information and was posted on the weekend. This had the potential to affect all 103 residents, families and visitors who would wish to review the information.	04/03/2026

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F0732 SS = C	Continued from page 20 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review,	F0732	Continued from page 20 Corrective Action The required Daily Nurse staffing information has been updated to include nursing staff (RN, LPN, TMA, CNA) on duty per shift, including the total number and actual hours worked along with the current resident census. Identifying other residents Current residents have the potential to be affected. Systemic Changes IDT will be educated on F732 Changed daily staffing posting production sheet Reviewed and revised daily staff posting policy. Monitoring DON/designee shall audit Nurse staffing daily requirements to ensure all required information is included daily x 7 days, then weekly x 3 weeks, then monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F0732 SS = C	Continued from page 21 the facility failed to ensure the required nurse staffing information included the required information and was posted on the weekend. This had the potential to affect all 103 residents, families and visitors who would wish to review the information. Findings include: During an observation on 3/9/26 at 7:27 a.m., the nurse staffing was posted in the main hallway where visitors entered. The posting was dated 3/6/26, it had the name of the facility at the top of the page, the date and the day of the week, the census, the nursing hours and the hours per patient day. Below these were listed the roles starting with the certified nursing assistant listed as 25 with a total of 189.5 hours. Licensed practical nurses were listed as four with a total of 29.5 hours. Registered nurses were listed as 10 with a total of 84 hours. The posting dated 3/6/26 was for Friday in addition, the posting lacked nurse staffing separated out by shifts and did not include any information on trained medication aides. During an interview on 3/12/26, staffing coordinator (SC)-D stated the nurse staffing was supposed to be posted daily which would include weekends. SC-D also verified the posting was supposed to include the staff working by shift and not just a total of all hours worked in a 24-hour period. During an interview on 3/12/26 at 12:16 p.m., the director on nursing (DON) stated the staff posting was supposed to be posted for families and residents so they would be able to see how many staff were working on each shift. The Daily Staff Posting dated 10/17/25, identified the posting would include the following information: “Content Requirement: Posting must include the number of nursing staff (RN, LPN, TMA, CAN) on duty per shift. Must list the total number and actual hours worked along with the current resident census.” The title identified the posting would be posted daily.	F0732		
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-	F0757	F757 Drug Regimen is Free from Unnecessary Drugs SS=D The facility failed to ensure timely implementation of a pharmacist recommendation and subsequent provider order to help prevent unnecessary medication use for 1 of 5 residents (R83) reviewed for unnecessary medications.	04/08/2026

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F0757 SS = D	Continued from page 22 §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 ensure timely implementation of a pharmacist recommendation and subsequent provider order to help prevent unnecessary medication use for 1 of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83's quarterly minimum data set (MDS) dated 1/19/26, identified intact cognition and diagnoses of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes mellitus, and hypertension. R83's provider orders dated 3/25/25, identified acidophilus (a supplement with beneficial bacterium) two times per day for prevention of urinary tract infections (UTI). A document, Physician/Provider Recommendation dated 9/12/25, identified a pharmacist recommendation to consider a trial discontinuation of acidophilus to help prevent polypharmacy, excessive pill burden, and unnecessary medication. The provider responded on 10/3/25 to discontinue lactobacillus (acidophilus) due to therapy completed. During an interview on 3/12/26 at 12:02 p.m., registered nurse (RN)-E, a nurse manager, stated the pharmacy recommendations went to the providers as soon	F0757	Continued from page 22 Corrective Action Resident #83 acidophilus medication was discontinued per physician order on 3/12/2026. Identifying other residents Current residents with pharmacy recommendations have the potential to be affected. All current residents reviewed to ensure pharmacy recommendations were processed. Systemic Changes Educate IDT regarding F757 Drug Regimen is Free from Unnecessary Drugs Educate staff responsible for processing orders on 757 Drug Regimen is Free from Unnecessary Drugs Monitoring DON/designee shall audit Pharmacy recommendations to ensure approved changes have been carried out and followed monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F0757 SS = D	Continued from page 23 as they got to the nurse managers. RN-E added she wasn't sure what happened with this one, her expectation would be that all orders were acted on. During an interview on 3/12/26 at 2:52 p.m., the pharmacist consultant (PC)-G stated she would expect follow up on pharmacy recommendations within 30 days. A policy regarding unnecessary medications, non-psychotropic, was not received.	F0757		
F0802 SS = F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record reviews the facility failed to have resident meals served within 45 minutes of the start of the posted scheduled mealtimes. This affected all 103 residents in the facility. Findings include: Signs posted throughout the facility indicated breakfast on Cedar, Elm and Spruce units started at 7:45 a.m. Breakfast on Willow (memory care unit) started at 8:15 a.m. Lunch on Cedar, Elm, and Spruce units started at 12:00 p.m., and lunch on Willow started at 12:30 p.m. Dinner on Cedar, Elm, and Spruce units started at 5:45 p.m., and dinner on Willow	F0802	Completion Date: 4/8/2026 F802 Sufficient Dietary Support Personnel SS=F The facility failed to have resident meals served within 45 minutes of the start of the posted scheduled mealtimes. This affected all 103 residents in the facility. Corrective Action Dietary Manager utilized dietary staff differently. Utilized another Dietary Aide rather than a R/D (runner/dish) Identifying other residents Current residents have the potential to be affected for each mealtime. Systemic Changes Director of Nursing or designee shall in-service staff including agency (RNs, LPNs, CNAs) regarding F802 Sufficient Dietary Support Personnel to include: Scheduled mealtimes All hands on deck during mealtimes Residents must be served meals within 45 minutes of scheduled mealtime	04/08/2026

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F0802 SS = F	Continued from page 24 started at 6:15 p.m. During an observation at the Cedar unit on 3/9/26 at 7:45 a.m., food arrived at the kitchenette, had been placed on the steam tables and had been temperature checked. One culinary aide (CA) was in the kitchenette, and two nurse assistants (NA)s were in the dining hall. The CA and NAs were observed conversing and looking into the dining hall with residents waiting for their meals. At 8:15a.m., the CA began dishing up plates of food and the NA's began placing trays of food into meal carts. At 8:28 a.m., one aide left the dining hall with the meal cart to hallway 1. The other aide stayed in the dining hall to serve residents present. The last resident on Cedar unit did not receive their meal until 9: 03 a.m. This was 1 hour and 18 minutes after the scheduled start of mealtime. During an observation on the Cedar unit on 3/9/26 at 12:00 p.m., the food had arrived at the unit and was ready to be served. The last resident did not receive their tray until 1:02 p.m. 1 hour after the scheduled start of mealtime. On 3/10/26 at 5:32 p.m. an announcement was made that dinner service would start 30 minutes later than scheduled. During an observation on the Cedar unit of 3/10/26 that began at 5:45 p.m., residents were in the dining room along with nursing staff, waiting for food to arrive. At 6:26 p.m., food arrived and was placed in the kitchenette steam tables. Trays were set up and placed in the tray carts to go to hallway 1. At 6:39 p.m., the tray cart left for hallway one and the first resident in the dining hall received their tray. The last resident received their tray at 7:12 p.m. 1 hour and 27 minutes after the scheduled start of mealtime. During an observation on the Spruce unit on 3/10/26 that began at 5:45 p.m., (the start of dinner service). The first tray was not passed until 6:35 p.m., with the last tray passed at 7:16 p.m. 1 hour and 31 minutes after the start of mealtime. During an observation on the Willow unit on 3/10/26 at 5:54 p.m., food had arrived on the unit. At 6:45 p.m. nursing staff were in the dining hall with the residents, but no culinary staff had arrived. Residents had started to get restless. At 6:59 p.m., culinary staff arrived on unit, and the meal service began. At 7:25 p.m., the last resident was served. 1 hour and 10 minutes after the scheduled start of mealtime.	F0802	Continued from page 24 Monitoring DON/designee shall audit mealtimes to ensure residents are served within 45 minutes of mealtime schedule Daily x 7 days, then weekly x 3 weeks, then monthly 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F0802 SS = F	Continued from page 25 During an interview on 3/10/26 at 6:45 p.m. registered nurse (RN)-A stated the facility had been on a streak where the dinner had been always late. During an interview on 3/11/26 at 12:52 PM CA-A stated the NA would give them the meal ticket, the CA would fill the plate and then the NA would set the tray up and deliver the meal. A lot of times there would be delays because either the food did not make it up in time, issues in the kitchen, and equipment forgotten or the CA would have to wait for nursing staff to get into the dining hall to start getting trays ready and getting them passed. During an interview on 3/12/26 at 9:35 a.m. NA-A stated several times the food would be late because staff would still be getting residents up and out of bed. When there were a lot of residents who needed assistance up it took more time. During an interview on 3/12/26 at 10:03 a.m. the culinary services manager (CSM) stated both the kitchen staff and the nursing staff worked together to make sure meals were passed timely. The times posted were the times when meal service began and passing of trays to the residents should begin at that time. An allowable amount of time would be 45 minutes for all residents to be fed, but anything beyond an hour from start of service was to long for residents to wait for meals. During an interview on 3/12/26 at 10:42 am the administrator and administrator of record both stated 45 minutes to an hour is ok for all residents on a unit to be served meals. Anything beyond one hour from start of mealtimes is not acceptable. On 3/12/26 at 11:48 a.m., an announcement was again made that the lunch service on that day would start 30 minutes late. The dining hall and service line policy was requested but not provided.	F0802		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help	F0880	Completion Date: 4/8/2026 F880 Infection Prevention & Control SS=E The facility failed to ensure that proper glove use and hygiene was completed during food service. This had the	04/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245366	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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F0880 SS = E	Continued from page 26 prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	Continued from page 26 ability to affect all 26 residents on the Willows unit Corrective Action C-A was provided with individual counseling regarding Infection Control, glove use, and hand hygiene while serving food. Identifying other residents Current Residents have the potential to be affected. Systemic Changes IDT will be educated on Hand Hygiene and Glove Use Dietary Personnel will be educated on Hand Hygiene and Glove Use. Hand Hygiene Policy was reviewed and remains appropriate. Monitoring Kitchen manager/designee shall perform observation audits on the units to ensure that proper glove use and hygiene was completed during food service Daily x 7 days, then weekly x 3 weeks, then monthly 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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F0880 SS = E	Continued from page 27 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure that proper glove use and hygiene was completed during food service. This had the ability to affect all 26 residents on the Willows unit. Findings include: On 03/10/2026 at 6:59 p.m., cook (C)-A arrived in dining room to begin plating meals on Willow unit. C-A began removing plastic coverings from food in steam table. C-A then left and went to another unit and grabbed a cart with cups. She then returned near steam table and donned gloves. No observation of hand sanitization. She grabbed a plate and ladle, placed them down, then went to the fridge and grabbed another metal tray and placed in the steam table. She then grabbed a plate and began plating food from steam table. Other staff members poured drinks and began to serve plated food. With the same gloves on, C-A went to another unit touching door handles on her way and returned carrying plates covers. With same gloved hands she placed them on the counter and grabbed another plate and began plating food. During plating of food she went to fridge, opened fridge, grabbed another metal container and placed it in the steam table with the same gloved hands. She then continued to plate food touching the bread of each sandwich with the same gloved hands and placing them on plates.During interview on 03/10/2026 at 7:26 p.m., C-A stated, "that is my bad." I should have taken off my gloves, went out there, sanitized my hands, and put on new gloves prior to plating food.During interview on 03/12/2026 at 10:38 a.m., the director of nursing (DON) stated that her expectation would be that the staff would have removed the gloves, completed hand hygiene, and donned new gloves prior to plating food.	F0880		

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Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/9/26-3/12/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		04/01/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 The following complaints were reviewed: H53667882C (2738091), H53667884C (2687795), H53667885C (2681119), H53667886C (2672774), H53667887C (2600886), H53667883C (2699210), NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal	20570	Completion Date: 4/8/2026 F657 Care Plan Timing and Revision SS=D The facility failed to update a resident’s care plan, including the resident's inability to safely smoke after a fall from wheelchair while smoking, for 1 of 1 resident (R106) reviewed for accidents.	04/08/2026

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20570	Continued from page 2 guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to update a resident's care plan for 1 of 1 resident (R106) reviewed for accidents. Findings include: R106's quarterly Minimum Data Set dated 1/8/26, identified R106 had diagnoses which included disease of spinal cord, dementia, diabetes mellitus, paranoid schizophrenia, insomnia, nicotine dependence, tobacco use, and repeated falls. In addition, R106's MDS identified he was moderately cognitively intact. R106's current care plan report identified he was at risk for falls. Interventions included the following: Call light positioned for easy access initiated on 4/10/25 Fall Review per facility protocol initiated on 4/10/25 Have commonly used articles within easy reach initiated on 4/10/25 Wheelchair-anti-rollbacks initiated on 5/19/25 Call don't fall sign placed initiated on 5/19/25 R106's care plan report identified R106 smoked. Interventions included the following: Assess for safe smoking practice upon admission, quarterly, and as needed initiated on 4/10/25 Educate/remind of the facility smoking policy as needed. Has agreed to follow the policy initiated on 4/10/25 Smoking material will be stored in locked drawer in room or designated safe area for example on person or in a pocket initiated on 4/10/25 The facility smoking list provided on 3/9/26, listed R106 as a current smoker. The facility's investigation of R106's fall on 1/26/26, identified the following:	20570	Continued from page 2 Corrective Action Resident #106 New Smoking and Fall Assessment completed. Resident #106 Smoking and fall care plans were updated and revised. Identifying other residents Current Residents with fall incidents have the potential to be affected. All residents who smoke care plans were audited and revised if necessary. Systemic Changes Education to IDT regarding F657 Care Plan Timing and Revision to include: Incident/Accident documentation Updating Care Plans (New care plan revision procedure) Education to nursing staff regarding F657 Care Plan Timing and Revision to include: Incident/Accident documentation Updating Care Plans (New care plan revision procedure) Incident Investigation Procedure was reviewed and remains appropriate. Care Plan Revision Procedure created Monitoring DON/designee shall audit Risk Management reports to ensure care plans have been updated/revised to address	

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20570	Continued from page 3 The date the incident occurred, the location, R106's description of the incident (he was unable), immediate actions taken (lifted off of the ground with an assist of two, brought inside, nasal bleeding stopped, sent to the emergency department for evaluation). The explanation was "Fell off his w/c (wheelchair) outside in the smoking area. Unable to explain incident." No statements gathered, no further notes on follow-up, no root cause analysis, no changes made to R106's care plan. During an interview on 3/11/26 at 2:36 p.m., registered nurse (RN)-D recalled the incident when R106 fell. RN-D was unsure if R106's care plan had been updated but did state his power of attorney no longer wanted R106 to smoke, RN-D reviewed the care plan and verified it had not been updated. During an interview on 3/12/26 at 11:36 a.m., the director of nursing (DON) verified there were no updates made to the resident's care plan after the incident. Incident Investigation Procedure dated 2/8/24, identified, "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator." The policy identified any corrective action would be documented and other pertinent data as necessary or required. The policy further identified, "Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures to ensure care plans are updated when necessary to meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are used and followed. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570	Continued from page 3 the root cause of fall incidents daily x 7 days, then weekly x 3 weeks, then monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	
20875	Adequate and Proper Nursing Care; Monitor TPR	20875	Completion Date: 4/8/2026	04/08/2026

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20875	Continued from page 4 CFR(s): MN Rule 4658.0520 Subp. 2 l Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to monitor weights to identify possible congestive heart failure (CHF) exacerbation for 1 of 1 resident (R119) reviewed for quality of care. Findings include: R119's entry Minimum Data Set (MDS) dated 3/6/26, identified R119's cognition had not been assessed. R119's diagnoses included acute on chronic CHF, acute resp failure with hypercapnia, diabetes mellitus type 2 (DM2), hypertension (HTN), morbid obesity, and obstructive sleep apnea (OSA). R119's 48-hour Care Plan (paper document) dated 3/6/26 indicated R119 is cognitively intact with admission diagnoses of acute diastolic heart failure and obesity. R119's care plan dated 3/12/26, instructed:Record weights a minimum of monthly or per MD/RDN.R119's provider orders dated 3/12/26 included:Daily weight one time a day related to acute diastolic (congestive) heart failure, ordered 3/9/26.Elevate legs and prevent extended periods where legs are down, every dayshift for lower extremity edema management.Bumetanide Oral Tablet 2 MG (Bumetanide) Give 1 tablet by mouth at bedtime related to acute on chronic diastolic (congestive) heart failure.Spironolactone Oral Tablet 25 MG (Spironolactone) Give 1 tablet by mouth one time a day related to acute on chronic diastolic (congestive) heart failure.R119's treatment administration record (TAR) dated 3/12/26, instructed staff to obtain a daily weight one time a day related to CHF, with order dated 3/9/26 at 12:51 p.m. R119's Admission/Readmission Tool dated 3/6/26 at 2:50 p.m., identified a most recent weight of 327.0 dated 9/23/25 while other most recent vitals were dated 3/6/26. Review of R119's weight record dated 3/12/26,	20875	Continued from page 4 F684 Quality of Care SS=D The facility failed to monitor weights to identify possible congestive heart failure (CHF) exacerbation for 1 of 1 resident (R119) reviewed for quality of care Corrective Action Resident #119 weight order is being completed and documented daily as ordered by provider and/or documented appropriately for refusals/notifications. Identifying other residents Current Residents with CHF diagnosis and/or Daily Weights orders have the potential to be affected. All residents with CHF diagnosis, request orders for weight frequencies. Systemic Changes IDT will be educated on the following: Daily Weights and documentation CHF Standing Orders for Skilled Nursing Licensed Nurses will be educated on the following: Daily Weights and documentation CHF Standing Orders for Skilled Nursing DON/Designee will review new admissions to identify CHF diagnosis and orders for Daily Weights are entered.	

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20875	Continued from page 5 identified an admission weight dated 3/6/26, a struck-out weight dated 3/10/26, and two weights on 3/11/26 (at 10:14 a.m. and 5:40 p.m.). This record was also reviewed on 3/9/26 and no weights were entered at that time. R119's nurse progress notes for 3/2026 were requested but not received. During an observation on 3/9/26 at 1:05 p.m., R119 was in their wheelchair in their room. They asked registered nurse (RN)-C to assist with elevating their legs on the bed. RN-C assisted with positioning bilateral legs on bed. R119 stated his physician wanted him to elevate his legs often to reduce swelling. During an interview on 3/11/26 at 3:39 p.m., RN-B stated staff obtain a weight on admission, residents with CHF would be weighed daily, and all residents were weighed weekly on their shower day. They stated the nurse enters the standing order when a resident with CHF is admitted. They confirmed their concern that weight gain in a CHF resident could be a sign of fluid retention, which could lead to breathing issues and the need for diuresis. RN-B stated they identified on 3/9/26 that R119 had no order for daily weights and entered the standing order. Reviewing R119's weight record, they confirmed that no admission weight was entered and R119 had a recorded weight gain of 19.1 pounds in one day (338.3 pounds on 3/10/26 to 357.4 pounds on 3/11/26). RN-B stated they were present at R119's admission, requested a mechanical lift weight, and observed it being done. During an interview on 3/12/26 at 10:11 a.m., RN-C stated vitals, including weight, would be taken immediately on admission. They stated the standing order was daily weights for three days then weekly unless there was a specific order for a resident with CHF or dietary concerns which required continuing daily weights. They confirmed they would be concerned for significant weight change in a resident with CHF. RN-C stated if there was a weight change, they would reweigh the resident and notify the physician of a significant change. During an interview on 3/12/26 at 10:15 a.m., RN-B stated they found R119's admission weight on the admission nurse's handwritten notes. RN-B stated they entered the weight historically in R119's medical record. RN-B stated the nurse that entered R119's weight on 3/10/26 thought it was entered incorrectly so RN-B struck the weight from R119's record.	20875	Continued from page 5 Monitoring DON/designee shall audit Daily weights to ensure orders are entered, completed and documented daily x 7 days, then weekly x 3 weeks, then monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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20875	Continued from page 6 During an interview on 3/12/26 at 10:24 a.m., director of nursing (DON) stated vitals, including weight would be taken on resident admission, then daily weight for three days to establish a baseline, and then weekly unless the resident has CHF or malnutrition diagnoses, which may require more frequent monitoring. The DON stated if there is a weight discrepancy, the electronic medical record would flag it in red, and they expected staff to reweigh the resident for accuracy, complete an assessment, and update the provider. The facility parameters for significant weight loss was more than 2 pounds overnight or 5 pounds in a week. With weight gain in CHF residents, the DON was concerned for fluid retention, shortness of breath, edema, and CHF exacerbation. Review of undated facility document of hand-written nurse notes indicated R119's admission weight was 352.8. The facility document Standing Orders for Skilled Nursing Facilities signed and dated 6/13/25, in admission to facility, indicated daily weights for residents with heart failure unless otherwise directed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee should review policies and procedures related to the admission process, initiating standing orders, and weight monitoring of residents with a diagnosis of congestive heart failure (CHF). Facility staff could be educated on weight monitoring including parameters, assessments, and provider notification. The DON and/or designee could audit resident admissions to ensure compliance. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20875		
20985	Dietary Staff Requirements Sufficient personn CFR(s): MN Rule 4658.0610 Subp. 1 Subpart 1. Sufficient personnel. The nursing home must employ sufficient personnel competent to carry out the functions of the dietary service. "Sufficient personnel" means enough staff to plan, prepare, and serve palatable, attractive, and nutritionally adequate meals at proper temperatures and appropriate times.	20985	Completion Date: 4/8/2026 F802 Sufficient Dietary Support Personnel SS=F The facility failed to have resident meals served within 45 minutes of the start of the posted scheduled mealtimes. This affected all 103 residents in the	04/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	**2501 RICE LAKE ROAD , DULUTH, Minnesota, 55811**

(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
20985	Continued from page 7 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record reviews the facility failed to have resident meals served within 45 minutes of the start of the posted scheduled mealtimes. This affected all 103 residents in the facility. Findings include: Signs posted throughout the facility indicated breakfast on Cedar, Elm and Spruce units started at 7:45 a.m. Breakfast on Willow (memory care unit) started at 8:15 a.m. Lunch on Cedar, Elm, and Spruce units started at 12:00 p.m., and lunch on Willow started at 12:30 p.m. Dinner on Cedar, Elm, and Spruce units started at 5:45 p.m., and dinner on Willow started at 6:15 p.m. During an observation at the Cedar unit on 3/9/26 at 7:45 a.m., food arrived at the kitchenette, had been placed on the steam tables and had been temperature checked. One culinary aide (CA) was in the kitchenette, and two nurse assistants (NA)s were in the dining hall. The CA and NAs were observed conversing and looking into the dining hall with residents waiting for their meals. At 8:15a.m., the CA began dishing up plates of food and the NA's began placing trays of food into meal carts. At 8:28 a.m., one aide left the dining hall with the meal cart to hallway 1. The other aide stayed in the dining hall to serve residents present. The last resident on Cedar unit did not receive their meal until 9: 03 a.m. This was 1 hour and 18 minutes after the scheduled start of mealtime. During an observation on the Cedar unit on 3/9/26 at 12:00 p.m., the food had arrived at the unit and was ready to be served. The last resident did not receive their tray until 1:02 p.m. 1 hour after the scheduled start of mealtime. On 3/10/26 at 5:32 p.m. an announcement was made that dinner service would start 30 minutes later than scheduled. During an observation on the Cedar unit of 3/10/26 that began at 5:45 p.m., residents were in the dining room along with nursing staff, waiting for food to arrive. At 6:26 p.m., food arrived and was placed in the kitchenette steam tables. Trays were set up and placed in the tray carts to go to hallway 1. At 6:39 p.m., the tray cart left for hallway one and the first resident in the dining hall received their tray. The last	20985	Continued from page 7 facility. Corrective Action Dietary Manager utilized dietary staff differently. Utilized another Dietary Aide rather than a R/D (runner/dish) Identifying other residents Current residents have the potential to be affected for each mealtime. Systemic Changes Director of Nursing or designee shall in-service staff including agency (RNs, LPNs, CNAs) regarding F802 Sufficient Dietary Support Personnel to include: Scheduled mealtimes All hands on deck during mealtimes Residents must be served meals within 45 minutes of scheduled mealtime Monitoring DON/designee shall audit mealtimes to ensure residents are served within 45 minutes of mealtime schedule Daily x 7 days, then weekly x 3 weeks, then monthly 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/12/2026**

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20985	Continued from page 8 resident received their tray at 7:12 p.m. 1 hour and 27 minutes after the scheduled start of mealtime. During an observation on the Spruce unit on 3/10/26 that began at 5:45 p.m., (the start of dinner service). The first tray was not passed until 6:35 p.m., with the last tray passed at 7:16 p.m. 1 hour and 31 minutes after the start of mealtime. During an observation on the Willow unit on 3/10/26 at 5:54 p.m., food had arrived on the unit. At 6:45 p.m. nursing staff were in the dining hall with the residents, but no culinary staff had arrived. Residents had started to get restless. At 6:59 p.m., culinary staff arrived on unit, and the meal service began. At 7:25 p.m., the last resident was served. 1 hour and 10 minutes after the scheduled start of mealtime. During an interview on 3/10/26 at 6:45 p.m. registered nurse (RN)-A stated the facility had been on a streak where the dinner had been always late. During an interview on 3/11/26 at 12:52 PM CA-A stated the NA would give them the meal ticket, the CA would fill the plate and then the NA would set the tray up and deliver the meal. A lot of times there would be delays because either the food did not make it up in time, issues in the kitchen, and equipment forgotten or the CA would have to wait for nursing staff to get into the dining hall to start getting trays ready and getting them passed. During an interview on 3/12/26 at 9:35 a.m. NA-A stated several times the food would be late because staff would still be getting residents up and out of bed. When there were a lot of residents who needed assistance up it took more time. During an interview on 3/12/26 at 10:03 a.m. the culinary services manager (CSM) stated both the kitchen staff and the nursing staff worked together to make sure meals were passed timely. The times posted were the times when meal service began and passing of trays to the residents should begin at that time. An allowable amount of time would be 45 minutes for all residents to be fed, but anything beyond an hour from start of service was to long for residents to wait for meals. During an interview on 3/12/26 at 10:42 am the administrator and administrator of record both stated 45 minutes to an hour is ok for all residents on a unit to be served meals. Anything beyond one hour from start of mealtimes is not acceptable.	20985		

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20985	Continued from page 9 On 3/12/26 at 11:48 a.m., an announcement was again made that the lunch service on that day would start 30 minutes late. The dining hall and service line policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure appropriate kitchen staff to allow residents to be served meals timely. The facility should create, review, and/or update or policies and procedures, and educate all staff on specific requirements to ensure that meals are served with acceptable time frames. The administrator, registered dietician, or designee should perform audits to ensure timely meals. The RD should also be part of the QAPI committee when food and nutrition services are involved. The facility should report results of those audits to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20985		
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to complete required tuberculosis (TB) testing	21426	Completion Date: 4/8/2026 MN Tuberculosis Prevention and Control The facility failed to complete tuberculosis screening for resident 115. Corrective Action Chest X-ray was completed per resident request over Two step TB. All residents received a new TB step if missing. Identifying other residents Current Residents have the potential to be affected. Systemic Changes	04/08/2026

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21426	Continued from page 10 for 1 of 6 residents (R115) reviewed for TB screening and testing. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline TB screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms. R115 was admitted to the facility on 2/3/26. R115's medical record lacked evidence TB testing had been completed. R115's 5-day Minimum Data Set (MDS) dated 2/6/26, identified R115 was cognitively intact. R115's diagnoses included unspecified disease of spinal cord, neoplasm of unspecified behavior of endocrine glands and other parts of nervous system, benign neoplasm of meninges, and multiple sclerosis (MS). R115's provider orders dated 3/12/26 included:Okay for chest x-ray 2 view to rule out tuberculosis.R115's medication administration record (MAR) dated 2/26, identified tuberculin PPD solution was administered intradermally one time for step 1 on 2/4/26 and tuberculin PPD solution was administered intradermally one time for step 2 on 2/18/26. There was no evidence of a task for these tests to be resulted. R115's immunization report dated 3/12/26, identified the TB 2 Mantoux test administered on 2/4/26 and 2/18/26 both had pending results. R115's nurse progress note dated 3/11/26 at 2:48 p.m., stated that R115 was made aware that two tuberculin tests they had received had no evidence of being read. R115 agreed to a chest x-ray. R115's radiology report dated 3/11/26 at 7:23 p.m., revealed a normal chest x-ray with no definitive evidence of TB. Review of facility TB screening records requested for 6 residents, including R115, dated 3/10/26, lacked documentation of R115's TB testing. During an interview on 3/11/26 at 9:23 a.m., R115 stated staff had informed them that their TB skin tests had not been resulted during their first month at the facility, so a chest x-ray was needed. R115 stated they	21426	Continued from page 10 IDT will be educated on Tuberculosis Policy Licensed Nurses will be educated on Tuberculosis Policy. Monitoring DON/designee shall perform Audits on 5 residents daily x 7 days, then weekly x 3 weeks, then monthly 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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21426	Continued from page 11 asked about repeating the skin test instead of the chest x-ray and reported staff told her the x-ray would be faster. R115 expressed concern about getting an x-ray due to their history of tumors but stated they had not shared that concern with staff. During an interview on 3/11/26 at 1:05 p.m., infection preventionist (IP) stated residents are screened for TB on admission. The process would be completed within 28 days. The IP stated if a skin test was not resulted between 48 and 72 hours of administration, they would repeat the intradermal skin test. If 2 skin tests had not been completed by 28 days after entering the facility, they would have obtained a chest x-ray or done a blood test. IP confirmed that R115's TB testing had not been completed in the first 28 days so a chest x-ray was ordered on 3/11/26 to rule out TB. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.	21535	Completion Date: 4/8/2026 F757 Drug Regimen is Free from Unnecessary Drugs SS=D The facility failed to ensure timely implementation of a pharmacist recommendation and subsequent provider order to help prevent unnecessary medication use for 1 of 5 residents (R83) reviewed for unnecessary medications. Corrective Action	04/08/2026

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21535	Continued from page 12 In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure timely implementation of a pharmacist recommendation and subsequent provider order to help prevent unnecessary medication use for 1 of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83's quarterly minimum data set (MDS) dated 1/19/26, identified intact cognition and diagnoses of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes mellitus, and hypertension. R83's provider orders dated 3/25/25, identified acidophilus (a supplement with beneficial bacterium) two times per day for prevention of urinary tract infections (UTI). A document, Physician/Provider Recommendation dated 9/12/25, identified a pharmacist recommendation to consider a trial discontinuation of acidophilus to help prevent polypharmacy, excessive pill burden, and unnecessary medication. The provider responded on 10/3/25 to discontinue lactobacillus (acidophilus) due to therapy completed. During an interview on 3/12/26 at 12:02 p.m., registered nurse (RN)-E, a nurse manager, stated the pharmacy recommendations went to the providers as soon as they got to the nurse managers. RN-E added she wasn't sure what happened with this one, her expectation would be that all orders were acted on. During an interview on 3/12/26 at 2:52 p.m., the pharmacist consultant (PC)-G stated she would expect follow up on pharmacy recommendations within 30 days. A policy regarding unnecessary medications,	21535	Continued from page 12 Resident #83 acidophilus medication was discontinued per physician order on 3/12/2026. Identifying other residents Current residents with pharmacy recommendations have the potential to be affected. All current residents reviewed to ensure pharmacy recommendations were processed. Systemic Changes Educate IDT regarding F757 Drug Regimen is Free from Unnecessary Drugs Educate staff responsible for processing orders on 757 Drug Regimen is Free from Unnecessary Drugs Monitoring DON/designee shall audit Pharmacy recommendations to ensure approved changes have been carried out and followed monthly x 3 months or until sustained compliance is achieved. Audit results shall be submitted to QAPI for analysis and to be addressed as appropriate.	

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21535	Continued from page 13 non-psychotropic, was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframes for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/10/2026

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/10/2026. At the time of this survey, Hilltop Healthcare Rehabilitation & Skilled Nursing was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:	K0000		04/03/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/10/2026

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K0000	Continued from page 1 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. Hilltop Healthcare and Rehabilitation & Skilled Nursing is a 3-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1974 & 1985 an additions were constructed to the building that were determined to be of Type II(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 140 beds and had a census of 103 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0222 SS = D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical	K0222	Completion Date: 4/3/2026 K0222 SS=D On 03/10/2026 at 1:30 PM, it was revealed by observation that the kitchen door is equipped with a pipe style handle over the panic hardware altering the mechanism of the hardware.	04/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/10/2026

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD , DULUTH, Minnesota, 55811

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K0222 SS = D	Continued from page 2 security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K0222	Continued from page 2 Corrective Action Pipe style handle over the panic hardware was removed. All Egress doors audited without issues. Systemic Changes Education related to K0222 provided to maintenance staff Education related to K0222 provided to IDT Monitoring All issues will be reported to the administrator and brought to QAPI until compliance is met. Audit 5 egress doors daily X 5 days, then weekly X 4 weeks or until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245366	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD , DULUTH, Minnesota, 55811

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K0222 SS = D	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.5.3, 7.2.1.5.10, and 7.2.1.5.10.2.This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/10/2026 at 1:30 PM, it was revealed by observation that the kitchen door is equipped with a pipe style handle over the panic hardware altering the mechanism of the hardware. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0222		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Fire Alarm System per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3, 14.4, 14.5.1, 14.6 This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 at 10:30 AM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that fire alarm system semi-annual inspection is occurring. An interview with the Maintenance Director verified	K0345	Completion Date: 4/9/2026 K0345 SS=F On 03/10/2026 at 10:30 AM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that fire alarm system semi-annual inspection is occurring Corrective Action Semi-annual inspection scheduled for 4/9/2026. Systemic Changes Education related to K0345 provided to maintenance staff Education related to K0345 provided to IDT Schedule in TELS created for Semi-Annual fire inspection. Monitoring	04/09/2026

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K0345 SS = F	Continued from page 4 this deficient finding at the time of discovery.	K0345	Continued from page 4 All issues will be reported to the administrator and brought to QAPI until compliance is met.	
K0347 SS = F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and test the resident room smoke detectors per NFPA 101 (2012 edition), Life Safety Code sections 4.6.12 and 9.6.2.10. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 03/10/2026 at 11:00 AM, it was revealed by a review of available documentation that no documentation was presented to confirm that inspection, testing, battery change(s) and tracking of age or manufacture date(s) of each residential device(s) is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0347	Completion Date: 4/3/2026 K0347 SS=F On 03/10/2026 at 11:00 AM, it was revealed by a review of available documentation that no documentation was presented to confirm that inspection, testing, battery change(s) and tracking of age or manufacture date(s) of each residential device(s) is occurring. Corrective Action All individual room smoke detectors have been audited. Systemic Changes Education related to K0347 provided to maintenance staff Education related to K3472 provided to IDT Policy created for in-room smoke detectors and monitoring Monitoring All issues will be reported to the administrator and brought to QAPI until compliance is met. Audit weekly that monthly detector checks are completed X 8 weeks or until compliance is met.	04/03/2026
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with	K0353	K0353 SS=F Findings include 1. On 03/10/2026 at 12:55PM, observation revealed that 2 sprinkler heads were loaded with dust in the Kitchen above the kitchen hood. 2. On	04/03/2026

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K0353 SS = F	Continued from page 5 NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101, 2012 edition, Sections 19.3.5.3, 9.7.5, NFPA 25, 2011 edition, sections 5.1, 5.1.1, 5.1.1.1, 5.1.1.2, 5.2.1.1.2, 5.2.1.1.4 and Table 5.1.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include 1. On 03/10/2026 at 12:55PM, observation revealed that 2 sprinkler heads were loaded with dust in the Kitchen above the kitchen hood. 2. On 03/10/2026 at 12:55PM, observation revealed that 2 sprinkler heads were corroded in the Kitchen above the kitchen hood. 3. On 03/10/2026 at 12:55PM, observation revealed that 2 sprinkler heads were corroded in the Kitchen by the dishwashing area. 4. On 03/10/2026 at 1:15 PM, observation revealed that a sprinkler head was obstructed by holiday decorations in Willow by the nurses station. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0353	Continued from page 5 03/10/2026 at 12:55PM, observation revealed that 2 sprinkler heads were corroded in the Kitchen above the kitchen hood. 3. On 03/10/2026 at 12:55PM, observation revealed that 2 sprinkler heads were corroded in the Kitchen by the dishwashing area. 4. On 03/10/2026 at 1:15 PM, observation revealed that a sprinkler head was obstructed by holiday decorations in Willow by the nurses station. Corrective Action Decorations removed immediately upon finding Two sprinkler heads were replaced Two sprinkler heads were cleaned Systemic Changes Education related to K0353 provided to maintenance staff Education related to K0353 provided to IDT Monitoring All issues will be reported to the administrator and brought to QAPI until compliance is met. Audit 10 sprinkler heads daily X 5 days, then weekly X 4 weeks.	
K0712 SS = F	Fire Drills	K0712	Completion Date: 4/3/2026	04/03/2026

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K0712 SS = F	Continued from page 6 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 at 11:40 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been completed during the Second Shift of the Second Quarter of 2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712	Continued from page 6 K0712 SS=F On 03/10/2026 at 11:40 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been completed during the Second Shift of the Second Quarter of 2025. Corrective Action Fire drill completed for all three shifts. Systemic Changes Education related to K0712 provided to maintenance staff Education related to K0712 provided to IDT Fire Drill schedule added to TELS for each quarter Monitoring All issues will be reported to the administrator and brought to QAPI until compliance is met. Audit Quarterly completed fire drills.	
K0918 SS = D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K0918	K0918 SS=D On 03/10/2026 at 10:20 AM, it was revealed by a review of available documentation that the facility failed to provide documentation for monthly generator testing performed by a contractor or the facility during maintenance of generator for April and May of 2025. Corrective Action Generator test completed.	04/03/2026

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K0918 SS = D	Continued from page 7 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.3.4.1 and 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 at 10:20 AM, it was revealed by a review of available documentation that the facility failed to provide documentation for monthly generator testing performed by a contractor or the facility during maintenance of generator for April and May of 2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918	Continued from page 7 Systemic Changes Education related to K0918 provided to maintenance staff Education related to K0918 provided to IDT Weekly Generator tests added to TELS Monitoring All issues will be reported to the administrator and brought to QAPI until compliance is met. Audit generator tests weekly X 4 weeks	
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is	K0921	Completion Date: 4/9/2026 K0921 SS=F On 03/10/2026 at 11:00 AM, it was revealed that the facility provided electric beds for all residents, and	04/09/2026

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K0921 SS = F Bldg. 01	Continued from page 8 performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities Code 2012 Edition, section 10.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/10/2026 at 11:00 AM, it was revealed that the facility provided electric beds for all residents, and that PCREE such as nebulizers, oxygen concentrators, portable suction units, and other electrical, medical equipment was present at the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0921	Continued from page 8 that PCREE such as nebulizers, oxygen concentrators, portable suction units, and other electrical, medical equipment was present at the facility. Corrective Action Full inventory of all electrical equipment that touches patients. Preventative maintenance completed on all devices. Completed PCREE electrical testing forms for all devices. Systemic Changes Education related to K0921 provided to maintenance staff Education related to K0921 provided to IDT PCREE policy reviewed and revised. Monitoring All issues will be reported to the administrator and brought to QAPI until compliance is met. Audit any new equipment, preventative maintenance, and broken equipment - PCREE weekly X 4 weeks.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 23, 2026

Administrator
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS
2501 RICE LAKE ROAD
DULUTH, MN 55811

RE: CCN: 245366
Cycle Start Date: March 12, 2026

Dear Administrator:

On April 22, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 23, 2026

Administrator
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS
2501 RICE LAKE ROAD
DULUTH, MN 55811

Re: Reinspection Results
Event ID: 1E3E54-H2

Dear Administrator:

On April 22, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 12, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us