Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2026

Administrator
PELICAN VALLEY HEALTH CENTER
211 EAST MILL AVENUE
PELICAN RAPIDS, MN 56572

RE: CCN:245373
Cycle Start Date: March 25, 2026

Dear Administrator:

On March 25, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

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 25, 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 25, 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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March 31, 2026

Administrator
PELICAN VALLEY HEALTH CENTER
211 EAST MILL AVENUE
PELICAN RAPIDS, MN 56572

Re: State Nursing Home Licensing Orders
Event ID: 1E3E67-H1

Dear Administrator:

The above facility survey was completed on March 25, 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:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us
Office: 218-332-5159

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

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: 245373	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE , PELICAN RAPIDS, Minnesota, 56572

(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 3/23/26 to 3/25/26, 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		04/03/2026
F0000	INITIAL COMMENTS On 3/23/26 to 3/25/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		04/15/2026
F0880 SS = D	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	Enhanced barrier precautions (EBP) have been implemented for R8. Enhanced barrier precautions are in place for all residents that require EBP precautions in accordance with facility's EBP policy. Facility's EBP policy has been reviewed. All nursing staff have been re-educated on EBP policy and procedures to ensure personal protective equipment (PPE) will be worn during transmission-based precautions. Infection Preventionist or designee will audit to ensure implementation of EBP	04/15/2026

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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F0880 SS = D	Continued from page 1 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 1 is in place according to Facility's EBP policy. Audits will be completed once a week for 4 weeks, then completed monthly for 3 months. Results of these audits will be taken to the QAPI committee for further recommendations.	

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F0880 SS = D	Continued from page 2 §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, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented in accordance with Centers for Disease Control (CDC) guidelines for 1 of 3 (R8) residents who were reviewed for enhanced barrier precautions. CDC guidelines dated 8/12/22, identified EBP are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. CDC guidelines updated 6/28/24 identified examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. R8's Significant Change Minimal Data Set (MDS) dated 2/23/26, identified R8 had mild cognitive impairment. R8 had a diagnosis that included heart failure, end-stage renal disease, and diabetes. R8 required maximuml assistance with personal hygiene and dressing, and needed touching assistance with toilet transfers. R8's Care Area Assessment (CAA) dated 2/20/26, identified R8 required staff assistance with toileting needs. Staff assists with toileting every two hours as needed. R8's care plan revised on 2/9/26, directed staff to use EBP due to venous access site for dialysis. R8 needs hemodialysis related to renal failure. Monitor dialysis access site daily. Resident	F0880		

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F0880 SS = D	Continued from page 3 had an IJ tunnel catheter (IJC) placed. Dialysis center to change dressing. R8 required assistance of one staff for personal hygiene and dressing. R8 received dialysis. R8's ADL report sheet, not dated, revealed R8 needed assistance to transfer to the toilet and was on EBP. During an observation/ interview on 3/23/26 at 10:24 a.m., R8 reported having dialysis stopped the previous week as her dialysis port was not working. R8 had a large, tan, non-transparent renal dressing on the upper right chest; the external limbs of the catheter were not showing. During an observation on 3/24/26 at 9:43 a.m., nursing assistant (NA)-A, went into R8's room and transferred R8 onto the toilet. R8's room did not have an EBP sign on the door, and no gowns were located outside the door or in R8's room. During an observation and interview on 3/24/26 at 9:45 a.m., NA-A knocked on R8's door and asked if R8 was done on the toilet. NA-A transferred R8 from the toilet to the wheelchair. NA-A verified she did not wear a gown when R8 was toileted as there were no signs on the door or gowns to identify R8 was on EBP. NA-A indicated there were gowns next to the door and a sign on the door indicating R8 was on EBP when R8 was receiving dialysis, but the sign and gowns were removed when R8 dialysis was put on hold, and a dressing covered the dialysis site. During an interview on 3/23/26 at 5:02 p.m., registered nurse (RN)-A indicated R8 had an internal jugular catheter (IJC) for hemodialysis, and the port was occluded (blockage) and was not receiving dialysis at this time. During an interview on 3/25/26 at 8:30 a.m., infection preventionist (IP) indicated R8's IJC is covered by a dressing applied by the dialysis unit, and staff were not to change the dressing unless the dressing comes off. Dialysis was stopped the previous week. The plan was to monitor labs and remove the IJC the following week. IP indicated a staff member removed the EPB sign and gowns last week when the IJC was covered, and dialysis was stopped. IP verified R8 should have been on the EBP, as R8 continued to have the IJC. IP verified R8 did not have a sign on the door or gowns by the room on 3/23/26 and 3/24/26. IP verified staff should have been wearing gowns when toileting resident, and during all high contact care. IP verified the EPB sign and gowns were replaced on 3/24/26 after becoming aware of being removed. IP indicated EPB were important to protect staff and residents from multidrug resistant organisms (MDROs). During an interview on 3/25/26 at 9:08 a.m., director of nursing (DON) verified staff should have used EBP when performing high contact activities, such as toileting, as R8 had an IJC. EBP precautions were important to protect staff and residents from MDROs. Review of facilty policy titled enhanced barrier precaution policy dated 4/11/24, revealed Enhanced	F0880		

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F0880 SS = D	Continued from page 4 Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in conjunction with contact precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multidrug-resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Gloves and a gown are applied prior to performing the high-contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and, wound care (any skin opening requiring a dressing). In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of chronic wounds include, but are not limited to: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers. Indwelling medical device examples include: central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE will be available outside of the resident rooms, and alcohol-based hand rub is readily accessible to staff. Residents, families and visitors are notified of the implementation of EBPs throughout the facility.	F0880		

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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 3/23/26 to 3/25/26, 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		04/15/2026

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

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PELICAN VALLEY HEALTH CENTER	**211 EAST MILL AVENUE , PELICAN RAPIDS, Minnesota, 56572**

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20000	Continued from page 1 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		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented in accordance with	21375	Enhanced barrier precautions (EBP) have been implemented for R8. Enhanced barrier precautions are in place for all residents that require EBP precautions in accordance with facility’s EBP policy. Facility’s EBP policy has been reviewed. All nursing staff have been re-educated on EBP policy and procedures to ensure personal protective equipment (PPE) will be worn during transmission-based precautions. Infection Preventionist or designee will audit to ensure implementation of EBP is in place according to Facility’s EBP policy. Audits will be completed once a week for 4 weeks, then completed monthly for 3 months. Results of these audits will be taken to the QAPI committee for further recommendations.	04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/25/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	**211 EAST MILL AVENUE , PELICAN RAPIDS, Minnesota, 56572**

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21375	Continued from page 2 Centers for Disease Control (CDC) guidelines for 1 of 3 (R8) residents who were reviewed for enhanced barrier precautions. CDC guidelines dated 8/12/22, identified EBP are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. CDC guidelines updated 6/28/24 identified examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. R8's Significant Change Minimal Data Set (MDS) dated 2/23/26, identified R8 had mild cognitive impairment. R8 had a diagnosis that included heart failure, end-stage renal disease, and diabetes. R8 required maximuml assistance with personal hygiene and dressing, and needed touching assistance with toilet transfers. R8's Care Area Assessment (CAA) dated 2/20/26, identified R8 required staff assistance with toileting needs. Staff assists with toileting every two hours as needed. R8's care plan revised on 2/9/26, directed staff to use EBP due to venous access site for dialysis. R8 needs hemodialysis related to renal failure. Monitor dialysis access site daily. Resident had an IJ tunnel catheter (IJC) placed. Dialysis center to change dressing. R8 required assistance of one staff for personal hygiene and dressing. R8 received dialysis. R8's ADL report sheet, not dated, revealed R8 needed assistance to transfer to the toilet and was on EBP. During an observation/ interview on 3/23/26 at 10:24 a.m., R8 reported having dialysis stopped the previous week as her dialysis port was not working. R8 had a large, tan, non-transparent renal dressing on the upper right chest; the external limbs of the catheter were not showing. During an observation on 3/24/26 at 9:43 a.m., nursing assistant (NA)-A, went into R8's room and transferred R8 onto the toilet. R8's room did not have an EBP sign on the door, and no gowns were located outside the door or in R8's room. During an observation and interview on 3/24/26 at 9:45 a.m., NA-A knocked on R8's door and asked if R8 was done on the toilet. NA-A transferred R8 from the toilet to the wheelchair. NA-A verified she did not wear a gown when R8 was toileted as there were no signs on the door or gowns to identify R8 was on EBP. NA-A indicated there were gowns next to the door and a sign on the door indicating R8 was on EBP when R8 was receiving	21375		

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21375	Continued from page 3 dialysis, but the sign and gowns were removed when R8 dialysis was put on hold, and a dressing covered the dialysis site. During an interview on 3/23/26 at 5:02 p.m., registered nurse (RN)-A indicated R8 had an internal jugular catheter (IJC) for hemodialysis, and the port was occluded (blockage) and was not receiving dialysis at this time. During an interview on 3/25/26 at 8:30 a.m., infection preventionist (IP) indicated R8's IJC is covered by a dressing applied by the dialysis unit, and staff were not to change the dressing unless the dressing comes off. Dialysis was stopped the previous week. The plan was to monitor labs and remove the IJC the following week. IP indicated a staff member removed the EPB sign and gowns last week when the IJC was covered, and dialysis was stopped. IP verified R8 should have been on the EBP, as R8 continued to have the IJC. IP verified R8 did not have a sign on the door or gowns by the room on 3/23/26 and 3/24/26. IP verified staff should have been wearing gowns when toileting resident, and during all high contact care. IP verified the EPB sign and gowns were replaced on 3/24/26 after becoming aware of being removed. IP indicated EPB were important to protect staff and residents from multidrug resistant organisms (MDROs). During an interview on 3/25/26 at 9:08 a.m., director of nursing (DON) verified staff should have used EBP when performing high contact activities, such as toileting, as R8 had an IJC. EBP precautions were important to protect staff and residents from MDROs. Review of facilty policy titled enhanced barrier precaution policy dated 4/11/24, revealed Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in conjunction with contact precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multidrug-resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Gloves and a gown are applied prior to performing the high-contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device	21375		

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21375	Continued from page 4 care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and, wound care (any skin opening requiring a dressing). In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of chronic wounds include, but are not limited to: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers. Indwelling medical device examples include: central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE will be available outside of the resident rooms, and alcohol-based hand rub is readily accessible to staff. Residents, families and visitors are notified of the implementation of EBPs throughout the facility. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should re-educate nursing staff to appropriately implement correct personal protective equipment (PPE) to be worn during transmission based precautions. The DON or designee could review and revise policies to ensure appropriateness. The DON or designee should perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		

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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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

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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.	

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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

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

(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
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

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

(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
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

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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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 24, 2026

Administrator
PELICAN VALLEY HEALTH CENTER
211 EAST MILL AVENUE
PELICAN RAPIDS, MN 56572

RE: CCN: 245373
Cycle Start Date: March 25, 2026

Dear Administrator:

On April 16, 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 24, 2026

Administrator
PELICAN VALLEY HEALTH CENTER
211 EAST MILL AVENUE
PELICAN RAPIDS, MN 56572

Re: Reinspection Results
Event ID: 1E3E67-H2

Dear Administrator:

On April 16, 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 25, 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