Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 1, 2026

Administrator
Benedictine Health Center Of Minneapolis
618 EAST 17TH STREET
MINNEAPOLIS, MN 55404

RE: CCN: 245266
Cycle Start Date: April 3, 2026

Dear Administrator:

On May 29, 2026, the Minnesota Departments 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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 1, 2026

Administrator
Benedictine Health Center Of Minneapolis
618 EAST 17TH STREET
MINNEAPOLIS, MN 55404

Re: Reinspection Results
Event ID: 1E3EDF-H2

Dear Administrator:

On May 29, 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 April 3, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 20, 2026

Administrator
Benedictine Health Center of Minneapolis
618 East 17th Street
Minneapolis, MN 55404

RE: CCN:245266
Cycle Start Date: April 3, 2026

Dear Administrator:

On April 3, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 July 3, 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 October 3, 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,



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

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Electronically delivered

April 20, 2026

Administrator
Benedictine Health Center of Minneapolis
618 East 17th Street
Minneapolis, MN 55404

Re: State Nursing Home Licensing Orders
Event ID: 1E3EDF-H1

Dear Administrator:

The above facility survey was completed on April 3, 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:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING B. WING	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center Of Minneapolis	618 EAST 17TH STREET , MINNEAPOLIS, Minnesota, 55404

(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 3/30/26 to 4/3/26, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		04/21/2026
F0000	INITIAL COMMENTS On 3/30/26 to 4/3/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed. H#: H52669006C (iQies:2808130) with a deficiency issued 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 that substantial compliance with the regulations has been attained.	F0000		04/21/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center Of Minneapolis	**618 EAST 17TH STREET , MINNEAPOLIS, Minnesota, 55404**

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F0880 SS = F	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 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	F0880	This Plan of Correction constitutes the facility's allegation of compliance. Submission of this Plan of Correction does not constitute an admission by the facility that the deficiency existed or that the statements contained in the Statement of Deficiencies are accurate. This Plan of Correction is prepared and submitted because it is required by state and federal law. Corrective actions: R73 and R15 completed treatment for scabies on 3/31/26. No other residents presenting with rashes have been identified. All patients requiring precautions audited to ensure precautions are in place, care planned and communicated to floor staff. Reeducation completed for all licensed nursing associates on Scabies, working after treatment of scabies, isolation/transmission-based precautions during an outbreak. Reeducation completed for all disciplines regarding proper PPE and precautions. Families and employees will be updated of infection outbreaks, required PPE, and information on the symptoms, treatments, and visiting policy when outbreaks occur. Education w/ IP on the expectation of contact tracing/line tracing notification and guidance on how to proceed with potential illnesses/outbreaks per facility policy. Auditing DON or designee will audit the infection line listing weekly for 12 weeks to ensure all infections are being monitored DON or designee to perform PPE audits for 4 staff on each floor weekly x 6 weeks, then 2 staff weekly	05/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

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Benedictine Health Center Of Minneapolis	**618 EAST 17TH STREET , MINNEAPOLIS, Minnesota, 55404**

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F0880 SS = F	Continued from page 2 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. §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 record review, the facility failed to properly manage a potential scabies outbreak in January 2026, resulting in additional rashes requiring scabies treatment for 2 of 2 residents (R73, R15) reviewed who were prescribed an antiparasitic oral medication. Further, upon discovery of R15 and R73's rashes, the facility failed to take appropriate steps to prevent the spread of possible scabies. This had the ability to affect all 85 residents residing in the care facility. In addition, the facility failed to ensure transmission-based precautions were followed, to include enhanced barrier precautions (EBP) and contact precautions for 2 of 4 residents (R24, R45) observed for proper infection control practices. Findings include: During record review it was discovered that 14 residents on the fourth floor and 2 residents on the second floor had a diagnosis of scabies in their chart dated 1/29/26. R73's annual Minimum Data Set, dated 1/29/26, indicated R73 was admitted to the care facility on 1/28/22 and dependent on staff for most activities of daily living (ADLs). R73's orders, dated 3/28/26, indicated an order for	F0880	Continued from page 2 on each floor x 6 weeks. All audit results will be reviewed with the Quality Council (QAPI program) to determine ongoing need and duration of audits.	05/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

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F0880 SS = F	Continued from page 3 2 doses of ivermectin (an antiparasitic medication used in two doses to treat scabies, among other parasitic infections) 15 milligrams (mg) to be given on 3/28/26 and 4/4/26. R73's care plan, printed 4/1/26, lacked evidence R73 was being treated for possible scabies infection and currently on transmission-based precautions. During observation and interview on 3/30/26 at 1:39 p.m., R73 stated he had been itching for weeks and was just recently started on something to help the itching, a pill he took a few days ago. On his door was a sign that indicated staff were to follow enhanced barrier precautions when in his room providing cares. R15's quarterly MDS, dated 2/2/26, indicated R15 was admitted to the care facility on 8/15/23 and was dependent on staff for most ADLs. R15's orders, dated 3/30/26, indicated an order for 2 doses of ivermectin 18mg to be given on 3/31/26 and 4/7/26. R15's care plan, printed 4/1/26, lacked evidence R73 was being treated for possible scabies infection and currently on transmission-based precautions. During an interview on 4/1/26 at 12:45 p.m., R15's family member (FM)-A stated she comes to the facility every Tuesday to give R15 a shower. FM-A stated R15 has been itching his skin and on 3/24/26 the severity of the itching had increased, stating R15 was severely itching with scratch marks on his chest and buttocks. FM-A stated she spoke with the 4th floor nurse manager and registered nurse (RN)-B on 4/26/26 who suggested they go check R15 for a rash. FM-A confirmed RN-B stated R15 had a rash and had "dust mites." FM-A stated that following day an evening nurse told her R15 had scabies. FM-A stated she was not provided education on what scabies was or any precautions she should take for herself. During an interview on 3/31/26 at 3:14 p.m., nurse manager and RN-B confirmed R15 and R72 were both being treated for scabies and R73 should be on contact precautions, not enhanced barrier precautions. RN-B also confirmed there was a scabies outbreak back in January on 4th and 2nd floor. During an interview on 4/1/26 at 8:44 a.m., the	F0880		05/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

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F0880 SS = F	Continued from page 4 infection preventionist (IP), who was in her role since mid-January of this year, stated the medical director (MD) (who has since retired) diagnosed the scabies infection back in January. The IP stated the MD indicated there was no need to do diagnostic skin scrapping of any residents with rashes, to just treat it as if it was scabies and ordered ivermectin as treatment. At that time, all staff were offered ivermectin as a precaution if they wanted to take it, but the IP did not believe there was any staff who developed any symptoms of scabies or staff who took ivermectin. The IP stated she was unsure if any contact tracing was completed for residents who had discharged within 6 weeks prior to the first outbreak to ensure they were aware they were exposed to scabies and was unable to provide any documentation that would show contact tracing was complete. The IP stated the expectation for TBP was that any resident being treated for scabies was on contact precautions until 24 hours after their second dose of ivermectin. The IP stated she was aware of 2 residents who had potential scabies but believed their treatment was done and was unaware they had only received one of two doses. The IP was unaware of any education that had been done with staff regarding scabies including what to monitor for and how to prevent the spread and was not involved in any education for current staff regarding the two new cases of scabies. The IP stated she was providing some general education about scabies to new staff during orientation. The IP confirmed she was not currently doing any contact or line tracing with the current potential scabies outbreak and was not doing any look back contact tracing of who discharged in the past 6 weeks and was possibly exposed to scabies. During an interview on 4/1/26 at 9:00 a.m., the assistant director of nursing (ADON) stated the rashes started out on second floor and originally it was thought to possibly be a cleanliness issue. The ADON stated they did some education with staff and put certain nursing aides in the unit with the rashes and they cleared up. The ADON stated "somebody" might have had scabies, but it was treated right away. The ADON stated she was not sure exactly what had happened on 4th floor as she was the second-floor nurse manager at the time, but the 4th floor nurse manager, RN-B, told her they had scabies "running ramped and still do." The ADON stated the "major wave" (of scabies) was over, and the floor managers were managing it now. The ADON stated she was not involved in any education regarding scabies, current or past. The ADON was aware of R15 being treated for scabies but no other	F0880		05/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

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Benedictine Health Center Of Minneapolis	**618 EAST 17TH STREET , MINNEAPOLIS, Minnesota, 55404**

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F0880 SS = F	Continued from page 5 residents. During an interview on 4/1/26 at 9:15 a.m., the administrator stated he believed the scabies outbreak at the end of January was mostly on second floor and the fourth floor had only one case that was treated. The administrator stated when they started getting multiple residents with a rash their MD was called in to look at the residents' skin and diagnosed the rashes as scabies. During a follow up interview on 4/1/26 at 10:03 a.m nurse manger and RN-B stated staff had completed skin checks of all residents on the 4th floor and currently only R15 and R73 have rashes and are being treated for scabies. RN-B stated she provided education to her staff on Mondays about the new cases of potential scabies, but that staff floated to all floors and there was not dedicated staff to just fourth floor where the 2 residents currently being treated for scabies reside. RN-B stated back at the end of January, during the first outbreak, two staff member had come to her with newly developed rashes and were given ivermectin as treatment. The staff were allowed to continue working during treatment. RN-B stated they had not done any contact tracing. During an interview on 4/1/26 at 10:57 a.m., Infection Control Assessment and Response (ICAR) stated any health care worker (HCW) must immediately be removed from work if they develop any symptoms, to including itching and/or a rash and be referred to their clinician and all HCWs should be educated to monitor their selves for symptoms (i.e. rash or itching). ICAR stated once a symptomatic HCW has been treated, they can come back to work but most wear a gown and gloves with all residents during cares. ICAR stated having two symptomatic HCW continuing to work could be why the facility was seeing another resurgence of scabies. ICAR further stated it would be the facility's responsibility to determine who discharged 6 weeks from the onsite of symptoms to provide them with awareness and education of possible scabies exposure. This along with a list of who is symptomatic, who is not, which staff have worked with symptomatic residents to try to find a connection or source. ICAR also confirmed having a medical record that indicated a resident was being treated for scabies would be an important part of preventing the spread if a symptomatic resident discharged or needed a higher level of care (i.e. hospitalization).	F0880		05/26/2026

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F0880 SS = F	Continued from page 6 During an interview on 4/2/26 licensed practical nurse (LPN)-A stated she was aware there were residents with a "rash" but was not sure what the treatment was. LPN-A stated she was aware to "cover up" (with a gown and gloves) when providing care and to wash her hands but was not provided specific education on what the rash was or to monitor herself for any symptoms. During an interview on 4/2/26 at 9:20 a.m., nursing assistant (NA)-C stated she was aware of a couple of residents with "rashes" but did not know what it was but was told to take precautions and wear a gown when in their rooms and to use a special soap with the residents. NA-C did not recall any specific education on monitoring herself for any rashes or itching. A facility policy titled Scabies, dated 6/2017, indicated Skin infestations by the mite Sarcoptes scabiei var. hominis are commonly known as scabies and are transmitted through direct contact with infected persons; less frequently, transmission may occur through contact with clothing or bed linens. The incubation period – the time from exposure to onset of symptoms – for primary infestation occurs as early as 10 days but is typically 4 to 6 weeks. The policy indicated if a resident is suspected of having scabies, orders would be obtained for skin scraping and the IP had authority to order skin scrapings under the direction of the MD. All suspected infected residents would be placed on contact precautions. The policy further indicated contact investigation would be completed to determine what HCW may need treatment and to provide them with education on scabies. According to the policy, all family members with exposure to scabies would be provided education on scabies, proper treatment, and encourage to obtain treatment from their physician. R24's quarterly Minimum Data Set (MDS) dated 2/23/26, indicated R24 was unable to talk, was dependent on staff for all activities of daily living, received oxygen, suctioning, had a tracheostomy, a tube feeding and a ventilator. MDS included diagnoses of chronic respiratory failure, diabetes, tracheostomy, gastrostomy tube, dysphagia, autonomic nervous system disorder, and nontraumatic subdural hemorrhage. R24's care plan dated 4/1/26, indicated R24 required Enhanced Barrier Precautions (EBP) related to diagnosis of respiratory failure, presence of tracheostomy and a gastric tube. The care plan's	F0880		05/26/2026

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F0880 SS = F	Continued from page 7 approach directed staff to implement precautions according to facility protocol. The care plan directed staff to apply gloves and gowns prior to high contact activities and hand sanitization after PPE removal. The EBP care plan was initiated on 1/14/25. On 2/25/26 a new goal was added, R24 “will not develop newly acquired MDRO or will not develop signs or symptoms of acute infection.” This care plan was last reviewed on 11/25/25. R24’s care plan dated 4/1/26, also indicated R24 had scabies on his left hand and arm. The care plan didn’t direct staff to follow contact precautions. Care plan identified 1/29/26 as the start date of the problem. This care plan was last reviewed on 1/29/26. During observation on 3/30/26 at 5:46 p.m., a Contact Precautions sign was taped to resident’s door. The sign instructed staff to wear a gown and gloves before entering R24’s room. During observation and interview on 3/31/26 at 3:56 p.m., R24 was in bed and observed nursing assistant (NA)-B turning and repositioning R24 using wedge cushions. NA-B was not wearing a gown. NA-B stated he knew there was a contact precaution sign on the door, but he forgot to put on a gown before entering R24’s room. During observation and interview on 4/1/26 at 7:52 a.m., observed a nurse entering R24’s room with a vital sign rolling stand. RN-A did not put on a gown before entering the room. RN-A obtained vital signs including oxygen levels and blood pressure. RN-A stated he only needed to use a gown if he provided personal cares. RN-A verified a contact precautions sign was taped on R24’s room door, which directed staff to wear gloves and a gown before entering the room. RN-A stated R24 was placed in contact precaution because R24 had a skin rash, but he believed it was resolved. R45 R45’s quarterly MDS dated 2/16/26, indicated R45 was unable to talk, and depended on staff for ADLs. MDS indicated diagnoses of chronic respiratory failure, hypertension, intellectual disabilities, dependence on respirator and pharyngeal dysphagia. MDS also indicated R45 had a tube feeding, a tracheostomy, was suctioned and used a ventilator. R45’s care plan dated 4/21/26, indicated R45 had a history of an antibiotic-resistant infection. The care	F0880		05/26/2026

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F0880 SS = F	Continued from page 8 plan directed staff to use principles of infection control and universal/standard precautions. In addition, R45 had a tracheostomy care plan which directed staff to use EBP precautions as indicated by facility policy. During observation and interview on 3/30/26 at 5:51 p.m., R45 was in bed, and a nurse was suctioning him. The nurse was not wearing a gown. Registered nurse (RN)-C stated he was supposed to wear a gown when he suctioned residents to prevent infections. RN-C stated he saw R45's call light on because he needed to be suctioned, so he didn't wear a gown. During interview on 4/2/26 at 2:00 p.m., the infection preventionist (IP) stated all staff were educated about EBP, the staff were instructed to use gowns and gloves when they provided hands on care, including suctioning. IP added, "if you are going to touch them [residents] then they need to follow EBP." Regarding contact precautions, IP stated any time the staff touched a resident they needed to wear a gown and gloves. IP stated staff needed to use a gown and gloves when turning and repositioning a resident and obtaining vital signs. IP stated she expected the nursing staff to wear personal protective equipment (PPE). The facility's policy titled Enhanced Barrier Precautions dated 3/28/24, indicated it was the policy of the community to protect residents and associates from the transmission of infectious diseases through use of appropriate precautions during resident care. The policy also indicated EBP expanded to the use of PPE beyond situations in which exposure to blood and body fluids was anticipated. It also referred to the use of gown and gloves during high-contact resident care activities that provided opportunities for transfers of multidrug-resistant organisms (MDROs) to staff's hands and clothing. The facility's policy titled Contact Precautions dated 9/2023, indicated "It is the policy of [company] to protect residents and associates from the transmission of infectious disease through use of appropriate precautions during resident care." The policy also indicated contact precautions are used, in addition to standard precautions to prevent nosocomial spread of organisms that can be transmitted by direct resident contact or by indirect contact of environmental surfaces of contaminated equipment.	F0880		05/26/2026

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F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure 7 out of 24 residents' (R63, R24, R5, R45, R47, R65, R20) fans were kept clean to provide a safe environment for residents with tracheostomies and/or ventilators. Findings include: R63 R63's annual Minimum Data Set (MDS) dated 3/6/26, indicated R63 was unable to speak, had moderately impaired decision making, and depended on staff members for all activities of daily living (ADLs). MDS indicated diagnoses of cardiorespiratory debility, tracheostomy, had a ventilator, and received oxygen and had a tube feeding. During observation on 3/30/26 at 5:35 p.m., R63 was sleeping in bed with her mouth open. A fan mounted on a wall was blowing air and there was dust accumulated on the grid. The fan was stopped, and dust was present on the fan blades. R63 woke during the visit but she was unable to answer questions. R24 R24's quarterly MDS dated 2/23/26, indicated diagnosis of cardiorespiratory debility, unable to talk, had a tracheostomy, a ventilator and a gastrostomy tube. MDS indicated R24 was dependent on staff members for ADLs. During observation on 3/30/36 at 5:50 p.m., R24 was awake, lying in bed in a supine position. R24 had a tracheostomy tube, a ventilator and a tube feeding. A fan mounted on the wall was on and dust had accumulated on the grid. The fan was stopped, and the fan's blades were dusty.	F0921	This Plan of Correction constitutes the facility's allegation of compliance. Submission of this Plan of Correction does not constitute an admission by the facility that the deficiency existed or that the statements contained in the Statement of Deficiencies are accurate. This Plan of Correction is prepared and submitted because it is required by state and federal law. Corrective action: R63, R24, R5, R45, R47, R65, R20 fans were cleaned by housekeeping staff on 4/7/28. All other residents within the facility with trach's/vents had fans reviewed for cleanliness and cleaned as needed. Education provided to housekeeping staff on importance of keeping fans clean, specifically on unit with residents of compromised respiratory status, including residents who are ventilator dependent Auditing DON or designee will audit 5 resident rooms for cleanliness weekly for 12 weeks. All audit results will be reviewed with the Quality Council (QAPI program) to determine ongoing need and duration of audits.	05/26/2026

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F0921 SS = E	Continued from page 10 R5 R5's quarterly MDS dated 3/2/26, indicated R5 was cognitively intact, needed moderate assistance with bathing, was dependent to put on footwear, needed set up with personal and oral hygiene. The MDS indicated diagnoses of traumatic brain injury, chronic obstructive pulmonary disease, had a tracheostomy which needed suctioning. During observation and interview on 3/30/26 at 1:42 p.m., R5 stated the fan was dusty and added, "the housekeepers clean the fan, but not very often." R45 R45's quarterly MDS dated 2/16/26 indicated R45 was nonverbal, had a diagnosis of cardiorespiratory debility, and was dependent on staff for all his ADLs. R45's face sheet dated 4/3/26, indicated diagnoses of unspecified intellectual disabilities, chronic respiratory failure with hypoxia, epilepsy, dependence on ventilator, tracheostomy, gastrostomy tube, and dysphagia. During observation on 3/30/26 at 5:48 p.m., R45 was in bed, and he had a tracheostomy, a ventilator and a tube feeding. A fan mounted on the wall had dust accumulated on the grid and its blades. R47 R47's 5-day MDS dated 3/28/26, indicated R47 had moderate impaired decision making, was unable to talk, and depended on staff for all ADLs. The MDS indicated diagnoses of progressive neurological condition, chronic respiratory failure, dependence on ventilator, tracheostomy and had a tube feeding. During observation on 3/30/26 at 6 p.m., R47 was in bed, did not respond to questions, and his mouth was wide open. R47 had a tracheostomy, was on a ventilator and a tube feeding. A wall-mounted fan was running and covered with dust. R20	F0921		05/26/2026

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F0921 SS = E	Continued from page 11 R20's quarterly MDS dated 1/13/26 indicated R20 was cognitively intact, was dependent on bathing, dressing and needed substantial assistance with dressing, and personal hygiene. R20's MDS included diagnoses of cardiorespiratory debility, oropharyngeal dysphagia, dependence on ventilator, and obstructive sleep apnea. MDS also indicated R20 had a tracheostomy, ventilator, received suctioning and had a tube feeding. During observation on 3/30/26 at 6:45 p.m., R20 was in his room, he had a tracheostomy, had a ventilator and had a tube feeding. A fan mounted on a wall was on, and dust was visible on the fan's grid. R20 said "yeah it is dirty, I am not sure when or who cleans the fan." R65 R65's quarterly MDS dated 2/10/26, indicated R65 was unable to speak and was dependent on staff for all ADLs. MDS indicated diagnoses of amyotrophic lateral sclerosis, anxiety, depression, respiratory failure, gastrostomy, oropharyngeal dysphagia, dependence on ventilator, and progressive bulbar palsy. MDS also indicated R65 received oxygen, suctioning, tube feeding, and tracheostomy cares. During observation on 4/1/26 at 12:05 p.m., R65 was not in his room. A fan mounted on a wall was on, and the fan's grid was covered with dust. When the fan was turned off there was also dust on the fan's blades. During interview on 4/1/26 at 1:43 p.m., registered nurse (RN)-A verified the fans observed in the residents' room were dusty. RN stated the fans should be cleaned to prevent allergies and/or infections. RN-A added, especially in the rooms with residents with respiratory problems. During interview on 4/1/26 at 1:51 p.m., nursing assistant (NA)-A stated, if the rooms needed to be clean, she would notify the housekeepers. NA-A stated she didn't pay attention to the fans and added "my priority is taking care of my patients." During interview on 4/2/26 at 8:31 a.m., housekeeper aid (HA)-A stated he cleaned the fans	F0921		05/26/2026

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F0921 SS = E	Continued from page 12 once a week. During interview on 4/2/26 at 8:34 a.m., the maintenance director (MD) indicated his department had a cleaning schedule. MD stated it was on a template, but he wasn't sure if the fans were included on the template. MD stated he did monthly rounds to check every room, but the fans were usually on, and it's difficult to determine if they were dirty when they are on. MD stated his expectation will be to check the fans every week and at least clean them monthly. During interview on 4/2/26 at 1:34 p.m., RN-D stated the fans in residents' rooms should be cleaned to prevent dust blowing in their room. RN-D added, especially in the rooms of residents with tracheostomies and ventilators to minimize the risk of further respiratory problems. Facility's procedure titled Resident Rooms-Routine Cleaning dated 11/2025, indicated maintaining clean and attractive surroundings without disrupting resident care. The undated Room Survey form included observing the room environment and furniture, including fans to ensure they were cleaned and functional.	F0921		05/26/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F0609	This Plan of Correction constitutes the facility's allegation of compliance. Submission of this Plan of Correction does not constitute an admission by the facility that the deficiency existed or that the statements contained in the Statement of Deficiencies are accurate. This Plan of Correction is prepared and submitted because it is required by state and federal law. Corrective actions R15 medications reviewed for discrepancies. Care plan/monitoring orders for R15 audited and verified accuracy All other residents on seizure medications audited for med errors, proper care plans, and medication monitoring orders in MAR and care plan. Provide education to nursing staff on medication	05/26/2026

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F0609 SS = D	Continued from page 13 procedures. §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 ensure a significant medication error was reported to the State Agency (SA) within 24 hours for 1 of 1 resident (R15) reviewed who received 1/10th of the prescribed dose of seizure prevention medication twice daily for 24 of days. Findings include: R15's quarterly Minimum Data Set (MDS) dated 2/2/26, indicated R15 had severe cognitive impairment, depended on staff for all activities of daily living, and had a diagnosis of hemiplegia and hemiparesis following cerebral infraction affecting the right dominant side. Other diagnoses included hypertension, diabetes, non-Alzheimer's dementia, seizures, and depression. R15's progress notes included: - 10/20/25 note at 4:16 p.m., indicated at 1:00 p.m., a nursing assistant (NA) reported to the nurse on duty R15 was shaking. Nurse indicated R15 was alert, and his right upper and lower extremities were shaking. Vs were obtained. R15's whole body started to shake, 911 was called, and R15 was taken to a local hospital at 1:25 p.m. -10/21/25 note indicated R15 returned at 11:40 p.m., with new order of Keppra 1000 milligrams (mg) twice a day. Order was faxed to pharmacy. R15 was alert, had dinner, denied pain and SOB. -10/21/25 note indicated the facility contacted the pharmacy and were informed the medication would be delivered next day by 9 a.m. R15's October's medication administration record (MAR) included an order dated 10/20/25 for levetiracetam 100 mg/ml, administer 100 mg orally twice a day. R15 received the first dose on 10/21/25. -10/31/25 note indicated R15 had a 60 second,	F0609	Continued from page 13 error reporting per company policy Educate facility staff on when to report a vulnerable adult situation and follow the chain of command regarding who to report to. Auditing DON or designee to audit all med errors for 12 weeks, all new admission/readmission orders for 6 weeks and then 3 admission/readmission orders for 6 weeks All audit results will be reviewed with the Quality Council (QAPI program) to determine ongoing need and duration of audits.	05/26/2026

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F0609 SS = D	Continued from page 14 jerking seizure at 9:30 p.m. The note indicated no other seizures were noted for the rest of the shift. A message was left for R15's brother, and the provider was notified. -11/13/25 note indicated at approximately 10:00 a.m., a housekeeper reported R15 was shaking in his room. R15 was sitting in his wheelchair and was experiencing a "violent seizures." R15 was unable to articulate but "he exhibited signs and symptoms of both pain and discomfort through his facial expressions and verbal cues. The seizures were recurrent, occurring in succession". Facility updated the provider and called R15's daughter. -11/13/25 note indicated at 10:56 a.m., the paramedics took R15 to the ER and his daughter went with them. -11/13/25 note indicated R15 return to the facility at 10:00 p.m. The hospital visit summary indicated lab work was negative for infection, lactate level was elevated, which may be consistent with the possible seizure episode. Daughter stated the EEG did not show definitive evidence of seizure activity. R15 also needed to have a neurologist follow-up appointment. R15's Active Orders dated 4/3/26 indicated an order for levetiracetam (anti-seizure medication) also known as Keppra. The Keppra order dated 11/14/25, indicated: "levetiracetam solution 100 milligrams (mg) /milliliter (ml), 1000mg oral twice a day." R15's Customer Concern form dated 11/17/25, indicated a pharmacy concern related to a "transcription dosage deviation." The concern form included a findings section which indicated on 10/20/25, R15 experienced severe seizures and was sent to the emergency department (ER). R15 was discharged back to the facility with a new order for Keppra 1000 mg orally twice a day. On 11/13/25, R15 experienced seizures, was evaluated in the ER and returned to the facility the same day. On 11/17/26 the nurse practitioner discovered R15 had been receiving 100 mg of Keppra twice a day instead of 1000 mg twice a day. R15's Event Report dated 11/19/26, identified as a Safety Event-Medication Error indicated the event occurred on 10/20/25. The error began on 10/20/25 and ended on 11/14/25. It was described as a medication error, "wrong dose- too little." The report indicated the following adverse extrapyramidal drug reactions- eg.- various combinations of tremors, postural unsteadiness, lack of slowness of movement, cogwheel rigidity, expressionless face,	F0609		05/26/2026

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F0609 SS = D	Continued from page 15 drooling, infrequent blinking, shuffling gate, decreased arm swing, and rigidity of muscles in the limbs, neck, and trunk. - 11/19/25 note indicated R15's brother was informed about Keppra medication error, "whereby resident was being given a less dosage than was prescribed. Family did not verbalize any concerns about the low dose." The note indicated on 11/14/25, the nurse practitioner (NP) discovered the Keppra dose needed to be increased to 10 ml, the changes were done immediately, and R15 had not had any seizures since. Lab work was ordered, and medications were faxed over by the NP. R15's November's MAR indicated R15 received 100 mg of Levitra twice a day until 11/13/25. On 11/14/25 R15 started to receive 1000 mg of Levitra twice a day. A provider note dated 11/14/25 indicated, "noted that dose was wrong…according to the ED report he [R15] should have been getting 1000 mg twice a day and he is getting the liquid at the facility, but he is only getting 100 mg twice a day so that order was changed -this possibly is why he was having breakthrough seizures. " During interview on 4/2/26 at 3:05 p.m., health unit coordinator (HUC) stated the nurses write the orders, then she transcribed them into the computer and gave back the order to the nurse to double check the accuracy of the order. HUC stated all orders were always checked twice. During interview on 4/2/26 at 3:00 p.m., licensed practical nurse (LPN)-A stated when a resident returned from a hospital, the nurse faxed the orders to the pharmacy. RN-E stated the nurses get the orders and the HUC or a nurse entered the orders on the computer. Once the orders were entered into the computer, the orders were checked by two people. During interview on 4/2/26 at 3:10 p.m., RN-E stated the nurses get physician orders, HUC entered the orders in the computer, and nurses verified the orders. RN-E added "all orders were double checked." RN-E stated she knew she had to report medications errors and complete paperwork following facility policy. During interview on 4/2/26 at 3:08 p.m., nurse manager RN-B stated on 10/20/25 R15 had seizures and was to the hospital for evaluation. R15 returned to the facility the same day with orders for Keppra	F0609		05/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

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F0609 SS = D	Continued from page 16 1000 mg twice a day. On 10/20/25 the Keppra order was transcribed by a nurse, but instead of 1000 mg the order was transcribed as 100 mg twice a day. R15 received 100 mg twice a day from 10/21/25 through 11/13/25. RN-B stated, on 11/13/26 R15 had another seizure, he was sent to the hospital for evaluation and returned the same day without new orders. R15 was to remain on 1000 mg of Keppra twice a day. On 11/14/25 RN-B received a call from R15's NP. NP was reviewing R15's 11/13/25 visit to the ER and realized a medication error had been made. RN-B received a verbal order for Keppra 1000 mg twice a day. RN-B stated she reported the medication error to the interim director of nursing and called the family. RN-B stated she didn't know if the medication error was reported to the SA. During interview on 4/2/26 at 3:02 p.m., the administrator and the company's regional nurse indicated the transcription error was not reported because it was not clear this caused harm to R15, so the error was internally fixed and R15 was monitored for further seizure activity. Facility's policy titled Medication Errors dated 8/31/23, indicated when a medication error was made in the preparation or administration of a drug or biological, the licensed staff provides any necessary immediate care, and notifies the attending provider and resident or resident representative.	F0609		05/26/2026
F0628 SS = D	Discharge Process 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	F0628	This Plan of Correction constitutes the facility's allegation of compliance. Submission of this Plan of Correction does not constitute an admission by the facility that the deficiency existed or that the statements contained in the Statement of Deficiencies are accurate. This Plan of Correction is prepared and submitted because it is required by state and federal law. Corrective actions R12 has returned from hospitalization. Bed hold policy discussed with responsible party. Provide bed hold policy to responsible party's during admissions and care conferences Provide education on providing bed hold and transfer notice during transfers for floor nurses.	05/26/2026

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F0628 SS = D	Continued from page 17 (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 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	F0628	Continued from page 17 Provide education on where to obtain written bed hold/notice of transfer policies for nurses to give to patients/families upon hospitalizations Educate floor nurses on documenting discussion of bed hold if obtaining a verbal Education to social work to follow up with responsible parties the next business day if no documentation of bed hold discussion is found. Auditing Administrator or designee to audit documentation of bed holds and transfer notices for 5 hospitalizations weekly x 12 weeks. All audit results will be reviewed with the Quality Council (QAPI program) to determine ongoing need and duration of audits.	05/26/2026

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F0628 SS = D	Continued from page 18 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 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.	F0628		05/26/2026

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F0628 SS = D	Continued from page 19 §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; (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,	F0628		05/26/2026

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F0628 SS = D	Continued from page 20 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 document review, the facility failed to provide a bed hold notice for 1 of 1 residents (R12) reviewed for hospitalization. Findings include: R12's quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, indicated R12 had moderately impaired cognition with no hallucinations, delusions or behaviors. During an interview and observation on 3/30/26 at 12:49 p.m., R12 was observed lying in bed. R12 responded to questions with yes or no answers. R12's face sheet, dated 4/2/26, indicated R12 had an identified emergency contact and who would also receive statements. R12's census log, printed 4/2/26, indicated R12 was on hospital leave from 2/22/26 and returned on 2/27/26. R12's progress notes, dated 2/15/26 to 2/28/26, were reviewed and identified the following: -2/22/26 at 11:22 p.m.: resident was sent to the hospital for "not responding well." Supervisor, resident's spouse, and on-call provider was notified. -2/23/26 at 2:42 a.m.: facility called to follow up with the hospital who continued to determine if resident was going to be admitted or discharged. -2/23/26 at 6:11 a.m.: facility received a call from hospital stating resident will be admitted for continued management and monitoring. -2/24/26 at 4:24 p.m.: facility called to get an update on resident. -2/27/26 at 2:23 p.m.: resident was escorted by	F0628		05/26/2026

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F0628 SS = D	Continued from page 21 two attended via stretcher at 11:50 am, awake and pleasant. Will update incoming shift. The progress notes lacked any indication a bed hold was completed prior to being sent to the hospital, or whether a bed hold was sent to the hospital after resident was transferred. R12's medical record was reviewed and lacked evidence a bed hold notice was provided for 2/22/26 hospitalization either in electronic medical record or in paper chart. During an interview on 4/2/26 at 12:32 p.m., registered nurse (RN)-G stated when a resident transferred to a hospital, the nurse obtained a bed hold which was documented in the electronic medical record. The forms were printed out for the resident to sign, if they were able, and then uploaded once signed. RN-G stated if the resident wasn't able to sign then they talked to the family. During an interview on 4/2/26 on 12:38 p.m., assistant director of nursing (ADON)-B stated the expectation was nurses on the floor would obtain the bed hold when the resident transferred to the hospital. ADON-B stated the form would be signed and uploaded into the electronic medical record. ADON-B could not locate the bed hold for R12's hospitalization for 2/22/26 to 2/27/26, and would have expected it to be done. ADON-B stated she would follow up on the bed hold to see if she could locate it. During an interview on 4/2/26 at 12:48 p.m., ADON/registered nurse (RN)-D stated they would expect nurses to complete the bed holds when a resident transferred to the hospital as if a resident wants their bed held, and it was important to do this. RN-D was unable to locate a completed bed hold for R12's 2/22/26 hospitalization. During an interview on 4/3/26 at 10:05 a.m., administrator stated there was no further documentation for R12's bed hold to provide. A facility policy titled Bed Hold, reviewed 10/23, indicated "Prior to or at the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident, responsible party, or legal representative written notice which restates and specifies the duration of the bed hold policy. If that is not possible due to extenuating circumstances (i.e. resident has gone to the hospital for an emergency), the Facility must	F0628		05/26/2026

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F0628 SS = D	Continued from page 22 communicate the information by telephone with the resident or responsible party/legal representative, and follow up by mailing the authorization/request form. A signature is not required on the written notice form, as long as the notice is issued to the resident or representative. If the notice is not signed, write the resident's name and how the notice was issued to the resident (e.g., "resident unable to sign," or "verbal consent by phone given by [name]."""	F0628		05/26/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §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:	F0641	This Plan of Correction constitutes the facility's allegation of compliance. Submission of this Plan of Correction does not constitute an admission by the facility that the deficiency existed or that the statements contained in the Statement of Deficiencies are accurate. This Plan of Correction is prepared and submitted because it is required by state and federal law. Corrective actions R88 MDS updated to accurately reflect discharge location. All MDS discharges home were audited to ensure correct coding from April 4th to current. Education provided for MDS coordinator on discharge coding and the importance of accuracy. Auditing Social services director or designee to audit All discharge MDS assessments weekly x 12 weeks. All audit results will be reviewed with the Quality Council (QAPI program) to determine ongoing need and duration of audits.	05/26/2026

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F0641 SS = D	Continued from page 23 Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (R88) reviewed for a closed record. Findings include: R88 was admitted to the facility on 1/30/26 with a diagnosis of aftercare following left knee joint replacement. During R88's stay at the facility, she received therapy services and was discharged from the facility to her home. R88's discharge MDS dated 2/9/26 indicated, R88 was discharged to a short-term general hospital. R88's electronic medical record (EMR) included a progress note dated 2/9/26 at 3:33 p.m. The progress note indicated R88 was discharged at 11:00 a.m. to her home with her sister. R88's sister provided transportation. Note identified a local home health agency would provide home services. Medication prescriptions were faxed to a local pharmacy, and R88 was discharged with medications as ordered. R88's Discharge Plan of Care indicated R88 returned home on 2/9/26. During interview on 4/2/26 at 9:29 a.m., corporate MDS/registered nurse (CMDS) verified, the R88's discharge MDS indicated R88 was discharged to a hospital. CMDS stated the facility's MDS nurse made a coding error, CMDS added she will make a MDS modification. Requested a MDS policy but was not provided.	F0641		05/26/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical,	F0656	This Plan of Correction constitutes the facility's allegation of compliance. Submission of this Plan of Correction does not constitute an admission by the facility that the deficiency existed or that the statements contained in the Statement of Deficiencies are accurate. This Plan of Correction is prepared and submitted because it is required by state and federal law. Corrective actions: R15 and R73 care plans updated to reflect current infections. R24 care plan updated to reflect current pressure	05/26/2026

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F0656 SS = D	Continued from page 24 mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure residents who were on transmission-based precautions for potential scabies had a documented diagnosis and care plan to ensure staff and any potential future care facilities were aware to help prevent the spread of scabies for 2 of 2 residents (R15 and R73) reviewed who were currently being treated for scabies. In addition, the facility failed to assure a skin care plan was updated to accurately reflect the skin problems for 1 of 1 resident (R24) reviewed for pressure areas. Findings include: R73's annual Minimum Data Set, dated 1/29/26, indicated R73 was admitted to the care facility on	F0656	Continued from page 24 ulcers. All patients with wounds/infections care plans reviewed and revised as necessary for accuracy Education provided for all licensed nurses on care planning and the importance of keeping them up to date with current and accurate information. Auditing DON or designee to audit 5 care plans per week for accuracy for 6 weeks, then 2 every week for 6 weeks. All audit results will be reviewed with the Quality Council (QAPI program) to determine ongoing need and duration of audits.	05/26/2026

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F0656 SS = D	Continued from page 25 1/28/22, and dependent on staff for most activities of daily living (ADLs). R73's orders dated 3/28/26, included an order for 2 doses of ivermectin (an antiparasitic medication used in two doses to treat scabies, among other parasitic infections) 15 milligrams (mg) to be given on 3/28/26 and 4/4/26 for dermatitis. R73's care plan, printed 4/1/26, lacked evidence R73 was being treated for possible scabies infection and currently on transmission-based precautions. During observation and interview on 3/30/26 at 1:39 p.m., R73 stated he had been itching for weeks and was just recently started on something to help the itching, a pill he took a few days ago. On his door was a sign that indicated staff were to follow enhanced barrier precautions when in his room providing cares. R15's quarterly MDS, dated 2/2/26, indicated R15 was admitted to the care facility on 8/15/23, and was dependent on staff for most ADLs. R15's orders, dated 3/30/26, included an order for 2 doses of ivermectin 18 mg to be given on 3/31/26 and 4/7/26. R15's care plan, printed 4/1/26, lacked evidence R73 was being treated for possible scabies infection and currently on transmission-based precautions. During an interview on 3/31/26 at 3:14 p.m., nurse manager and RN-B confirmed R15 and R72 were both being treated for scabies, not dermatitis and was not sure why ivermectin was written for a diagnosis of dermatitis. RN-B also stated R73 should be on contact precautions, not enhanced barrier precautions. During a follow up interview on 4/1/26 at 10:03 a.m., RN-B confirmed R15's and R73's electronic medical record lacked any evidence they were being treated for scabies and should. During an interview on 4/1/26 at 10:57 a.m., Infection Control Assessment and Response (ICAR) stated having a medical record that indicated a resident was being treated for scabies would be an important part of preventing the spread if a symptomatic resident discharged or needed a higher level of care (i.e. hospitalization). A facility policy titled Comprehensive Assessments and Care Planning, dated 2/26/26, indicated a	F0656		05/26/2026

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F0656 SS = D	Continued from page 26 comprehensive, person-centered interdisciplinary care assessment of the residents' condition is used to develop consistent quality care and must accurately reflect the residents' status to include disease diagnosis and health conditions. R24 R24's quarterly Minimum Data Set (MDS) dated 2/23/26, indicated R24 was unable to talk, and was dependent on staff members for all activities of daily living, turning, repositioning, and transfers. MDS indicated R24 was at risk of developing pressure areas, had pressure areas and open lesions, and had pressure-reducing devices for his chair and bed. R24's Face Sheet dated 4/1/26, indicated R24 was admitted to facility on 11/19/24. The face sheet indicated diagnoses of chronic respiratory failure, nontraumatic subdural hemorrhage, dependence on respirator, tracheostomy, gastrostomy, dysarthria following cerebral infarction, moderate protein-calorie malnutrition, pressure areas and iron deficiency anemia. R24's Active Orders report dated 4/1/26, included the following orders related to resident's skin problems: Pro-stat (concentrated, liquid protein medical food designed to manage pressure injuries, wounds and protein-energy malnutrition). Cares for dry blisters with a diagnosis of Bullous Pemphigus (large fluid-filled blisters) Wound care for his left lateral distal leg pressure area. Wound care for his left lateral proximal leg pressure area. Osmolyte 1.2 60 milliliters (ml) per hour for 20 hours via gastric tube. Eucerin cream for dry skin. Wound care for left heel Wound care for pressure area on left ear. Wound care for pressure area under the left side where trach ties were secured. Weekly skin checks on bath days.	F0656		05/26/2026

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F0656 SS = D	Continued from page 27 R24's care plan report dated 4/1/25, included a care plan titled "Alteration in Skin Integrity" related to diagnoses of diabetes and decreased mobility. The care plan had three sections: problem, goal and approach. The Problem section included the following information: Problem dated 11/20/24, indicated R24 had several pressure areas on admission, located on his coccyx, right scapula, right thigh and left thumb. Problem was updated on 4/10/25, and indicated R24 still had a pressure area on his coccyx, left ear and right scapula. The problem section was last updated on 7/8/25, and indicated pressure areas on his coccyx and right scapula. The Goal section dated 11/20/24 indicated "resident's skin alteration will heal without infection." The Approach section included the following information: The approach section, dated 11/20/24 directed staff to Encourage adequate nutrition and hydration. Encourage adequate nutrition Monitor for indication of infection, contact MD if present. Physical therapy/occupational therapy for screening as appropriate. Treatment/dressing per MD orders. Turning and repositioning every 2-3 hours and as needed. The approach section dated 9/26/25 directed staff, Use pillows for repositioning him off bony prominences including his coccyx, scapula and other areas prone to breakdown. Use specialty mattress and float his heels or use protectors. Positioning for comfort.	F0656		05/26/2026

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F0656 SS = D	Continued from page 28 The Care Plan report indicated the skin care plan was last reviewed/revised on 11/25/25 at 6:07 pm. The care plan lacked interventions to address R24's ongoing skin changes. R24's Wound Care visit report dated 3/19/26, indicated R24 had a stage 2 pressure area on his left lateral distal leg, a stage 2 left lateral proximal leg, a stage 2 pressure area on his left ear and a right pressure area under the left side of the tracheostomy plastic part. R24's current physician orders included wound care orders for the pressure areas listed above. R24's Skin Assessments dated 3/23/26, and 3/30/26, indicated R24's skin was clean, dry and intact. During interview on 4/1/26 at 7:54 a.m., RN-A stated, R24 had several pressure areas and was seen weekly by the wound care specialist. RN-A stated the nurses were responsible for obtaining or receiving new wound care orders, but the care plan was updated by the nurse manager. During interview on 4/2/26 at 1:34 p.m., RN- B stated the care plans were updated as needed to reflect resident's medical changes. RN-B added the care plans were reviewed and updated when a MDS assessment was completed. RN-B verified the last time R24's approach section of the care plan was updated, was done on 9/26/25. Between 9/26/25 and 4/1/26 R24 wounds and wound care orders were changed but the care plan was not updated. RN-B stated she expected the care plans would be accurate and reflected resident's problems, goals, and interventions. Facility's policy titled Comprehensive assessment and Care Planning dated 2/26/26, indicated a registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals, and sign and certify that the assessment was completed. The assessment must accurately reflect the residents' status. The policy also indicated the facility should use the results of the assessment to develop, review and revise the residents' person-centered comprehensive care plan.	F0656		05/26/2026
F0684 SS = D	Quality of Care CFR(s): 483.25	F0684	This Plan of Correction constitutes the facility's allegation of compliance. Submission of this Plan of Correction does not constitute an admission by the facility that the deficiency existed or that the	05/26/2026

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F0684 SS = D	Continued from page 29 § 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to monitor for signs and symptoms of bleeding and failed to follow up with provider to reinstate an anticoagulant medication for 1 of 1 resident (R31) reviewed for change in condition. In addition, the facility failed to obtain laboratory results and update the primary provider in a timely manner to initiate treatment for a urinary infection for 1 of 1 resident (R31) reviewed for urinary infection. Findings include: F31's comprehensive Minimum Data Set (MDS) dated 3/20/26, indicated R31 was comatose, depended on staff members for activities of daily living, and received food and medications through a tube feeding. MDS indicated R31 received oxygen, had a tracheostomy, received oral suctioning, and had a gastrostomy tube. MDS indicated diagnoses of stroke, atrial fibrillation, heart failure, hypertension, nontraumatic intracerebral hemorrhage, acute and chronic respiratory failure, persistent vegetative state, autonomic dysreflexia and unspecified convulsions. Anticoagulant R31's March Medication Administration Record (MAR) indicated R31 received 5 mg of Eliquis twice a day from 3/1/26 through the morning dose on 3/9/26. R31's progress notes indicated 3/9/26 at 2:02 a.m., R31's urine was dark red. The nurse contacted on-call provider to report R31's status. On-call nurse practitioner (NP) directed staff to continue to monitor and wait until the next day. On-call NP ordered to continue Eliquis as ordered due to risk of clotting. 3/9/26 at 3:49 p.m. R31's NP was updated about	F0684	Continued from page 29 statements contained in the Statement of Deficiencies are accurate. This Plan of Correction is prepared and submitted because it is required by state and federal law. Corrective actions: R31 medication was resumed on 3/25/26. Monitoring orders in place for anticoagulant orders. All residents on anticoagulants medication list verified for accuracy. Monitoring orders and care plans audited and in place for all patients on anticoagulants. Education provided to nursing staff on symptom monitoring for patients on anticoagulants. Education provided to all licensed nurses to specify that Held medications will have documentation to include: Reason for hold Length of time to be held Symptoms to monitor for holding of medication When hold period ends/when to update provider with observations for further clinical decision making Provide education to nursing staff regarding process of lab ordering, receiving results and notifying the provider per facility policy. Auditing DON or designee will audit all held medications for appropriate documentation in progress notes weekly for 12 weeks and 5 lab results received for 6 weeks then 3 lab results for the 6 weeks for appropriate provider and responsible party notification.	05/26/2026

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F0684 SS = D	Continued from page 30 hematuria (blood in urine), and she held the Eliquis. 3/9/26 at 10:59 p.m. note indicated R31's brief was changed 3 times, still had blood in the urine, and staff were waiting for lab results. 3/10/26 at 11:00 p.m. note indicated hematuria was noted again and a urine sample was collected. A fax request was sent to lab to be picked up the next day. 3/17/26 at 10:47 a.m. note indicated provider will hold/discontinue Eliquis because of "bleeding of the resident." 3/24/26 at 3:45 p.m. note indicated "daughter wanted Eliquis restarted." NP was contacted and she restarted previous Eliquis order. R31 receive the first dose in the morning. R31's Active Orders report dated 4/1/26 included an order for Eliquis 5 milligrams (mg) twice a day. This order was dated 3/25/26. During interview on 3/31/26 at 11:17 a.m., family member (FM)-A stated on 3/8/26, she noted blood in R31's urine and reported it to the nurse on duty. On 3/9/26 she was informed R31's Eliquis was placed on hold. FM-A stated she visited R31 every day and helped staff to provide cares for her, including changing her brief. FM-A stated after 3/8/26, she did not see any blood in R31's urine, and the staff did not report further bleeding episodes to her. On 3/24/26, FM-A visited R31 while nurse on duty administered the morning medications. R31's Eliquis was not administered. FM-A talked to the nurse and found out the Eliquis had been on hold since 3/9/26. FM-A stated she asked nurse on duty to call the NP and asked her to restart the medication. The nurse contacted the NP, and the medication was restarted on 3/24/26. During interview on 4/2/26 at 12:50 p.m., assistant director of nursing (ADON) stated the Eliquis order on the MAR was written as 'hold/discontinued' because their computer program discontinues any medication placed on 'hold'. ADON verified she contacted the NP and wrote the 3/17/26 progress note. The 3/17/26 indicated provider will hold/discontinue Eliquis because of "bleeding of the resident." ADON verified the electronic medical record (EMR) lacked documentation about further bleeding monitoring after 3/10/26. ADON stated the facility failed to clarify the order to hold the Eliquis. ADON stated her expectation was for nursing staff to monitor, document bleeding and update the NP.	F0684	Continued from page 30 All audit results will be reviewed with the Quality Council (QAPI program) to determine ongoing need and duration of audits.	05/26/2026

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F0684 SS = D	Continued from page 31 ADON added, the order also needed to include directions to monitor for bleeding, and when to update the NP on a pre-determined date. Urinary infection, R31's progress notes indicated, 3/9/26 at 2:02 a.m., R31's urine was dark red, and a urine sample was collected. Contacted on-call provider to report R31's status. On-call nurse practitioner (NP) directed staff not to send the urine sample to the laboratory, continue to monitor, and wait until the next day. On-call NP ordered to continue Eliquis as ordered due to risk of clotting. 3/9/26 at 3:49 p.m. R31's NP was updated about hematuria (blood in urine), and she ordered a urinalysis, and held R31's Eliquis. Sample was sent to the laboratory. 3/9/26 at 10:59 p.m. note, indicated R31's brief was changed 3 times, still had blood in the urine, and staff were waiting for lab results. 3/10/26 at 12:46 p.m. note indicated the urine sample was cancelled by the laboratory due to wrong spelling of resident's name. Laboratory advised them to send a new sample. 3/10/26 at 11:00 p.m. note indicated hematuria was noted again and a urine sample was collected. The staff faxed the lab to request the urine sample to be picked up the next day. 3/11/26 at 12:58 p.m. note indicated the urinalysis sample was picked up by the lab. 3/11/26 at 3:11 p.m., indicated the staff left a message to NP regarding the urinalysis lab report. 3/11/26 at 3:53 p.m. note indicated the NP called back, gave no new orders and instructed staff to wait for urine culture results since the results were negative for nitrate. R31's progress notes lacked documentation about urine culture results or contacting the provider to obtain orders for an antibiotic. R31's laboratory culture results faxed to facility on 3/15/256 indicated growth of >100,000 CFU/ml Escherichia coli and >100,000 CFU/ml Proteus mirabilis.	F0684		05/26/2026

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F0684 SS = D	Continued from page 32 R31's March MAR did not include documentation of resident receiving an antibiotic. During interview on 3/31/27 at 11:17 a.m., FM-A stated one of the symptoms R31 displayed when she had a urinary infection was the presence of blood in the urine. FM-A asked the nurse on duty to call the provider and to request laboratory work to check for a urinary infection. FM-A stated the nurse contacted the primary provider and a urine sample was going to be picked up on 3/9/26. On 3/10/26 FM-A was informed a new urine sample needed to be collected because R31's name was not properly spelled. The second sample was collected on 3/11/26. On 3/12/26 the nurse told her the urinalysis was negative. FM-A stated on 3/13, 3/14, 3/15 and 3/16 she asked the staff for the urine culture results. On 3/17/26, FM-A stated R31 had a thick light brown-amber discharge in her brief. FM-A called the nurse on duty and asked her if the culture results were back from the laboratory. FM-A stated on 3/18/26, the nurse on duty told her R31 was started on an antibiotic for a urinary infection. FM-A stated, apparently the staff contacted the provider on 3/17/26. FM-A stated she was upset because nobody called her to inform her about the new orders. Later, FM-A received a copy of the laboratory reports and noted the culture results were faxed to the facility on 3/15/26. FM-A stated she was unable to understand why the nursing staff waited until she asked about the results to do something. FM-A stated, "I am upset thinking she [R31] was uncomfortable with a urinary infection, and she was unable to communicate her discomfort." During interview on 4/2/26 at 8:46 a.m., registered nurse (RN)-H stated, when a urine sample was collected it should be accurately labeled with residents' name, date, time, and resident's medical record number. RN-H stated the laboratory usually collected samples by 3 p.m. on their regular days, and as needed if a lab test needs to be done as soon as possible. During interview on 4/2/26 on 4/2/26 at 8:51 a.m., health unit coordinator (HUC) stated the nurse collected urine samples, completed a lab form and placed it in the laboratory binder. HUC stated the nurses needed to make sure the sample was collected. If a sample was not collected, they needed to contact the lab. HUC stated the laboratory faxed the results to the appropriate nurses' station. During interview on 4/2/26 at 9:06 p.m., nurse manager/RN-B stated after the laboratory collected	F0684		05/26/2026

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F0684 SS = D	Continued from page 33 a urine sample, the expectation was for the nurses to look for the results. If the results were not faxed by the end of their shift, the nurse needed to call the laboratory and request the results. RN-B added if the results were not available, the next shift needed to follow up. Once the results were available, the nurses needed to call the doctors with the results. During interview on 4/2/26 at 12:29 p.m., assistant director of nursing (ADON) stated R31's urine sample was picked up on 3/9/26, but her name was spelled incorrectly. ADON stated on 3/10/26, the family asked about the lab results. A new sample was obtained and was sent to the lab. ADON stated on 3/15/26, the lab faxed the results, but facility staff called the NP on 3/18/26, and obtained orders for an antibiotic. ADON added the results should have been called as soon as they were available. ADON stated the nurses took too long to call the NP, and R31's infection could have worsened. During interview on 4/2/26 on 4/2/26 at 1:34 p.m. RN-D, who was covering for a vacant nurse manager position, stated lab results should be called to the providers as soon as they become available. RN-D stated she didn't see the results, didn't have an explanation for the delay, and had no other information. Facility's policy titled Change in Condition, Resident Examination and Evaluation dated 11/10/25 indicated it was the policy that a resident examination and evaluation was completed upon admission, with a change in physical function, or with an acute change in condition. When a significant change in the resident's physical, mental, or psychosocial status was identified by the licensed nurse, or when there was a need to significantly alter treatment. The licensed nursing associate consulted with attending provider and notified the resident representative.	F0684		05/26/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F0757	This Plan of Correction constitutes the facility's allegation of compliance. Submission of this Plan of Correction does not constitute an admission by the facility that the deficiency existed or that the statements contained in the Statement of Deficiencies are accurate. This Plan of Correction is prepared and submitted because it is required by state and federal law. Corrective actions: R2 and R-79 provider orders updated to include antipsychotic monitoring, target behaviors,	05/26/2026

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F0757 SS = D	Continued from page 34 §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 observation, interview and document review, the facility failed to monitor for orthostasis, a common side effect of antipsychotic medication, for 2 of 5 (R2 and R79) residents reviewed for unnecessary medications who also had a history of falls. Findings include: A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension ... [which can] lead to dizziness, syncope, falls ... it should be evaluated by both history and measurement ... Risk factors include systemic diseases causing autonomic instability (e.g., diabetes, alcohol dependence, Parkinson's disease), dehydration, drug-drug interactions, and age." R79 R79's annual Minimum Data Set (MDS), dated 3/13/26, indicated R79 was cognitively intact and independent with most activities of daily living (ADLs). The MDS further indicated R79 had taken antipsychotic medications during the look-back period. R79'd orders indicated an order for lurasidone (an atypical antipsychotic medication), dated 3/12/25, 40 milligrams (mg) once a day for schizophrenia, and risperidone (an atypical antipsychotic medication),	F0757	Continued from page 34 orthostatic hypotension monitoring, and AIMS observations per protocol. All patients on antipsychotics had provider orders updated to include antipsychotic monitoring, target behaviors, orthostatic hypotension monitoring and AIMS observations per protocol. Educate nurse managers/nurses on antipsychotic medication monitoring policy and the expectation for obtaining monthly orthostatic blood pressures, completing AIMS observations per protocol and having target behaviors and side effect monitoring in place. Auditing DON or designee to audit All new antipsychotic orders to ensure that orders for orthostatic blood pressures are entered for12 weeks. All audit results will be reviewed with the Quality Council (QAPI program) to determine ongoing need and duration of audits.	05/26/2026

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F0757 SS = D	Continued from page 35 dated 3/31/26, 5mg twice a day for bipolar. R79's electronic medical record (EMR) lacked any evidence orthostatic blood pressure was being monitored. R79's progress notes, dated 3/24/26, directed staff to provide R79 with a water pitcher at the beginning of each shift to help "manage her blood pressure." R79's progress note, dated 3/17/26, indicated staff found R79 sitting on the bathroom floor, stating she lowered herself to the floor after she felt dizzy. R79's progress note, dated 2/5/26 indicated staff met with R79 related to a recent fall. R79's progress note, dated 1/22/26, R79 was found on the floor outside the smoking area. R79's progress note, dated 1/1/26, R79 fell coming inside from the smoking area. During an interview on 4/2/26 at 9:12 a.m., R79 stated she feels dizzy at times which causes her to fall. During an interview on 4/2/26 at 9:20 a.m., stated R79 had falls "once and awhile" and was able to ambulate independently around the facility and would call staff for help if she felt unsafe. R2 R2's significant change MDS, dated 3/13/26, indicated R2 was cognitively intact and dependent on staff for most ADLs. The MDS further indicated R2 took antipsychotic medications during the look-back period. R2's orders, dated 2/5/26, indicated an order for clozapine (an atypical antipsychotic medication) 300 mg at bedtime for paranoid schizophrenia. R2's electronic medical record (EMR) lacked any evidence orthostatic blood pressure was being monitored. During an interview on 4/2/26 at 11:10 a.m., clinical manager and registered nurse (RN)-B stated R2 had a fall with major injury and was currently only walking with physical therapy and was pivot transferring with staff. RN-B further stated R79 would fall if her blood pressure dropped, causing her to get dizzy. RN-B confirmed that neither R2 nor R79 had care planned or ordered interventions to monitor orthostatic blood pressure, stating it would be a "good idea" for R79 with her history of falls and dizziness. During an interview on 4/2/26 at 2:10 p.m., the regional director stated it was expected that orthostatic blood pressure be monitored monthly for residents on antipsychotic medications. A facility policy titled Psychotropic Medication use, dated 9/7/23, indicated medication side effects to be monitored (i.e. orthostatic blood pressure.)	F0757		05/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/03/2026**

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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 3/30/26 to 4/3/26, 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. The following complaints were reviewed: H#: H52669006C (iQies:2808130). NO licensing orders	20000		04/21/2026

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/03/2026**

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20000	Continued from page 1 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		04/21/2026
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility	20550	Corrected	05/26/2026

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20550	Continued from page 2 failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (R88) reviewed for a closed record. Findings include: R88 was admitted to the facility on 1/30/26 with a diagnosis of aftercare following left knee joint replacement. During R88's stay at the facility, she received therapy services and was discharged from the facility to her home. R88's discharge MDS dated 2/9/26 indicated, R88 was discharged to a short-term general hospital. R88's electronic medical record (EMR) included a progress note dated 2/9/26 at 3:33 p.m. The progress note indicated R88 was discharged at 11:00 a.m. to her home with her sister. R88's sister provided transportation. Note identified a local home health agency would provide home services. Medication prescriptions were faxed to a local pharmacy, and R88 was discharged with medications as ordered. R88's Discharge Plan of Care indicated R88 returned home on 2/9/26. During interview on 4/2/26 at 9:29 a.m., corporate MDS/registered nurse (CMDS) verified, the R88's discharge MDS indicated R88 was discharged to a hospital. CMDS stated the facility's MDS nurse made a coding error, CMDS added she will make a MDS modification. An MDS policy was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20550		05/26/2026

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21695	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 4 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure 7 out of 24 residents' (R63, R24, R5, R45, R47, R65, R20) fans were kept clean to provide a safe environment for residents with tracheostomies and/or ventilators. Findings include: R63 R63's annual Minimum Data Set (MDS) dated 3/6/26, indicated R63 was unable to speak, had moderately impaired decision making, and depended on staff members for all activities of daily living (ADLs). MDS indicated diagnoses of cardiorespiratory debility, tracheostomy, had a ventilator, and received oxygen and had a tube feeding. During observation on 3/30/26 at 5:35 p.m., R63 was sleeping in bed with her mouth open. A fan mounted on a wall was blowing air and there was dust accumulated on the grid. The fan was stopped, and dust was present on the fan blades. R63 woke during the visit but she was unable to answer questions. R24 R24's quarterly MDS dated 2/23/26, indicated diagnosis of cardiorespiratory debility, unable to talk, had a tracheostomy, a ventilator and a gastrostomy tube. MDS indicated R24 was dependent on staff members for ADLs. During observation on 3/30/36 at 5:50 p.m., R24 was awake, lying in bed in a supine position. R24 had a tracheostomy tube, a ventilator and a tube feeding. A fan mounted on the wall was on and dust had accumulated on the grid. The fan was stopped, and the fan's blades were dusty. R5	21695	Corrected	05/26/2026

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21695	Continued from page 4 R5's quarterly MDS dated 3/2/26, indicated R5 was cognitively intact, needed moderate assistance with bathing, was dependent to put on footwear, needed set up with personal and oral hygiene. The MDS indicated diagnoses of traumatic brain injury, chronic obstructive pulmonary disease, had a tracheostomy which needed suctioning. During observation and interview on 3/30/26 at 1:42 p.m., R5 stated the fan was dusty and added, "the housekeepers clean the fan, but not very often." R45 R45's quarterly MDS dated 2/16/26 indicated R45 was nonverbal, had a diagnosis of cardiorespiratory debility, and was dependent on staff for all his ADLs. R45's face sheet dated 4/3/26, indicated diagnoses of unspecified intellectual disabilities, chronic respiratory failure with hypoxia, epilepsy, dependence on ventilator, tracheostomy, gastrostomy tube, and dysphagia. During observation on 3/30/26 at 5:48 p.m., R45 was in bed, and he had a tracheostomy, a ventilator and a tube feeding. A fan mounted on the wall had dust accumulated on the grid and its blades. R47 R47's 5-day MDS dated 3/28/26, indicated R47 had moderate impaired decision making, was unable to talk, and depended on staff for all ADLs. The MDS indicated diagnoses of progressive neurological condition, chronic respiratory failure, dependence on ventilator, tracheostomy and had a tube feeding. During observation on 3/30/26 at 6 p.m., R47 was in bed, did not respond to questions, and his mouth was wide open. R47 had a tracheostomy, was on a ventilator and a tube feeding. A wall-mounted fan was running and covered with dust. R20 R20's quarterly MDS dated 1/13/26 indicated R20 was cognitively intact, was dependent on bathing, dressing and needed substantial assistance with dressing, and personal hygiene. R20's MDS included diagnoses of cardiorespiratory debility, oropharyngeal dysphagia, dependence on ventilator, and obstructive sleep apnea. MDS also indicated R20 had a tracheostomy, ventilator, received suctioning and had a tube feeding.	21695		05/26/2026

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21695	Continued from page 5 During observation on 3/30/26 at 6:45 p.m., R20 was in his room, he had a tracheostomy, had a ventilator and had a tube feeding. A fan mounted on a wall was on, and dust was visible on the fan's grid. R20 said "yeah it is dirty, I am not sure when or who cleans the fan." R65 R65's quarterly MDS dated 2/10/26, indicated R65 was unable to speak and was dependent on staff for all ADLs. MDS indicated diagnoses of amyotrophic lateral sclerosis, anxiety, depression, respiratory failure, gastrostomy, oropharyngeal dysphagia, dependence on ventilator, and progressive bulbar palsy. MDS also indicated R65 received oxygen, suctioning, tube feeding, and tracheostomy cares. During observation on 4/1/26 at 12:05 p.m., R65 was not in his room. A fan mounted on a wall was on, and the fan's grid was covered with dust. When the fan was turned off there was also dust on the fan's blades. During interview on 4/1/26 at 1:43 p.m., registered nurse (RN)-A verified the fans observed in the residents' room were dusty. RN stated the fans should be cleaned to prevent allergies and/or infections. RN-A added, especially in the rooms with residents with respiratory problems. During interview on 4/1/26 at 1:51 p.m., nursing assistant (NA)-A stated, if the rooms needed to be clean, she would notify the housekeepers. NA-A stated she didn't pay attention to the fans and added "my priority is taking care of my patients." During interview on 4/2/26 at 8:31 a.m., housekeeper aid (HA)-A stated he cleaned the fans once a week. During interview on 4/2/26 at 8:34 a.m., the maintenance director (MD) indicated his department had a cleaning schedule. MD stated it was on a template, but he wasn't sure if the fans were included on the template. MD stated he did monthly rounds to check every room, but the fans were usually on, and it's difficult to determine if they were dirty when they are on. MD stated his expectation will be to check the fans every week and at least clean them monthly. During interview on 4/2/26 at 1:34 p.m., RN-D stated the fans in residents' rooms should be cleaned to prevent dust blowing in their room. RN-D	21695		05/26/2026

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21695	Continued from page 6 added, especially in the rooms of residents with tracheostomies and ventilators to minimize the risk of further respiratory problems. Facility's procedure titled Resident Rooms-Routine Cleaning dated 11/2025, indicated maintaining clean and attractive surroundings without disrupting resident care. The undated Room Survey form included observing the room environment and furniture, including fans to ensure they were cleaned and functional. SUGGESTED METHOD FOR CORRECTION: The Administrator or designee could review the current policies and procedures to ensure all resident environments and equipment are clean and in good repair. The Administrator could educate staff on those policies and procedures and designate someone to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		05/26/2026

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	245266	A. BUILDING **01 - MAIN BUILD...** B. WING	**03/31/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on March31, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Health Center of Minneapolis, 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	K0000		05/26/2026

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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K0000 Bldg. 01	Continued from page 1 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: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: Benedictine Health Center of Minneapolis is a 5-story building with a full basement that was built in 1969 was determined to be of Type II(222) construction. Each floor of this facility that provides care and sleeping-rooms, is divided into smoke compartments. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 85 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		05/26/2026

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K0918 SS = F Bldg. 01	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. 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 maintain the 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 8.3.7.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 3/31/2026, at 9:00 AM, it was revealed by a review of available documentation, the facility was not conducting either a specific gravity test or conductance test on the emergency generator	K0918	On 3/31/2026 the Maintenance Director ordered a continuance battery tester. It was delivered on 4/2/2026. The maintenance director conducted the test on the generator battery. The specific gravity test will be conducted on the emergency generator monthly. The maintenance director will be responsible to make sure the specific gravity test is done on the emergency generator as required. The maintenance director will report to Quality Council monthly to determine ongoing need and the duration of the audits.	05/26/2026

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K0918 SS = F Bldg. 01	Continued from page 3 batteries. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		05/26/2026
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for 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 staff interview, the facility failed to maintain the fire sprinkler system per NFPA 25 (2011 edition) (5.2.2.2). This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 3/31/2026, at 10:00 AM, it was revealed by observation several wires in contact with the sprinkler system by room 401A and 201A. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	On 3/31/2026 the Maintenance Director ties up the electrical wires that were touching the sprinkler pipes in both rooms 401A and 201A. The maintenance staff will check the sprinklers in the facility to make sure that there are no wires in contact with the sprinkler system. The maintenance staff will monitor any contracted vendors that install any wires to make sure that no wires are in contact with the sprinkler pipes. The maintenance director will report to Quality Council monthly to determine ongoing need and the duration of the audits.	05/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/31/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center Of Minneapolis	**618 EAST 17TH STREET , MINNEAPOLIS, Minnesota, 55404**

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K0541 SS = D Bldg. 01	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition), section 5.2.3.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 3/31/2026, at 10:13 AM, it was revealed by observation in that the Linen Chute in Room 220B failed to close and latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0541	On 3/31/2026 the Maintenance Director installed a new door closure on the linen chute Room 220B. The new door closure was tested and it was able to close and latch. The maintenance director or his designee will audit the linen chute door for closure and latching monthly. The maintenance director will be responsible to make sure linen chute doors close and latch. The maintenance director will report to Quality Council monthly to determine ongoing need and the duration of the audits.	05/26/2026
K0293 SS = A Bldg. 01	Exit Signage CFR(s): NFPA 101	K0293		05/26/2026

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K0293 SS = A Bldg. 01	Continued from page 5 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 7.10 and 19.2.10.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 3/31/2026 at 9:40 AM, it was revealed by observation that there were no exit signs in the basement by room 003 to direct persons to an exit in the event of an emergency. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0293		05/26/2026
K0311 SS = A Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by:	K0311		05/26/2026

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K0311 SS = A Bldg. 01	Continued from page 6 Based on observation and staff interview, the facility failed to maintain the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 3/31/2026 at 9:41 AM, observations and staff interview revealed ceiling tiles were missing in the Electrical Equipment Room 001. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0311		05/26/2026