Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 4, 2026

Administrator
Flagstone
12500 CASTLEMOOR DRIVE
EDEN PRAIRIE, MN 55344

RE: CCN: 245312
Cycle Start Date: March 20, 2026

Dear Administrator:

On April 29, 2026, the Minnesota Department 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

April 7, 2026

Administrator
Flagstone
12500 CASTLEMOOR DRIVE
EDEN PRAIRIE, MN 55344

RE: CCN:245312

Cycle Start Date: March 20, 2026

Dear Administrator:

On March 20, 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 June 20, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 20, 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flagstone	12500 CASTLEMOOR DRIVE , EDEN PRAIRIE, Minnesota, 55344

(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 An Emergency Preparedness survey was conducted 3/16/26 through 3/20/26 at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.475. The facility was in full compliance.	E0000		04/15/2026
F0000	INITIAL COMMENTS On 3/16/26 to 3/20/26, a standard recertification survey was conducted at your facility. In addition, multiple complaint investigations were also completed. Your facility was not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H53128541C (iQIES# 1128589) H53128542C (iQIES# 1128591) H53128560C (iQIES# 2738904) The following complaint was reviewed: H53128123C (iQIES# 2797452). An incidental finding was discovered and cited at F689. 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		04/15/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care.	F0552	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission is not an admission of or agreement with the deficiencies or conclusions contained in the department inspection report.	04/21/2026

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

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

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F0552 SS = D	Continued from page 1 The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to obtain and document informed consent, including an explanation of risks and benefits, for 1 of 5 residents (R43) reviewed for the use of psychotropic medications. Findings include: R43's quarterly Minimum Data Set (MDS) dated 2/4/26, indicated R43 had both long-term and short-term memory impairment and severely impaired cognitive decision-making skills. The MDS indicated R43 had Alzheimer's disease, anxiety, depression, and a "psychotic disorder". R43's order summary dated 3/18/26, indicated R43 had an order for 50 milligrams (mg) of Seroquel (an antipsychotic medication) twice a day for psychosis with a start date of 3/12/26. The order summary also included an order for 25 mg of Seroquel daily for psychosis with a start date of 3/12/26. R43's medical record was reviewed and lacked evidence that consent for the use of the Seroquel at the current dose and frequency was obtained prior to the medication being administered. During an interview on 3/19/26 at 9:39 a.m., licensed practical nurse (LPN)-A stated he worked with R43 frequently and was her nurse today. LPN-A stated he had	F0552	Continued from page 1 The facility immediately obtained and documented informed consent for the identified resident receiving psychotropic medication, including clear explanation of risk and benefits. On 3/31/26 the Clinical Coordinators & Clinical Administrator completed a house-wide audit of all residents receiving psychotropic medications to ensure informed consent was present. All findings identified were corrected. On 4/9/26, the Informed Consent Policy was reviewed by the Administrator and Director of Nursing and remained accurate. Licensed staff were reeducated on regulatory requirements and resident rights related to treatment decisions. The Director of Nursing/designee will monitor compliance by auditing new psychotropic medication orders weekly following the Interdisciplinary Team (IDT) meeting to ensure checklist and policy are utilized. Weekly audits will take place for one month and monthly thereafter for 3 months. Results will be reviewed at quarterly QA meetings to ensure sustained adherence.	

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F0552 SS = D	Continued from page 2 reviewed R43's medical record and was unable to find documentation that consent had been obtained for R43's Seroquel, but did believe he had talked with resident representative (RR)-A and obtained verbal consent. During an interview on 3/19/26 at 12:05 p.m., RR-A confirmed he was R43's power of attorney. RR-A stated he had been informed of R43's medication changes in the past, but did not believe he had been informed of the most recent March updates to R43's antipsychotic medications, including the Seroquel that was started on 3/12/26. During an interview on 3/19/26 at 11:58 a.m., the nurse manager for the unit, registered nurse (RN)-B, stated that when psychotropic medication updates were made, the floor nurses were in charge of contacting family, discussing the risks and benefits of the medications, and obtaining consent for the medication. RN-B stated they had a form that included the risks of psychotropic medications that RR's would sign and would be uploaded to the medical record. The facility's Psychotropic Medication Use policy dated 3/2025, indicated informed consent was to be obtained for the use of psychotropic medications used for behavior management.	F0552		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this	F0605	The facility immediately reviewed and clarified PRN psychotropic medication orders for the identified resident to ensure specific, individualized indications for use were included to guide appropriate administration and prevent unnecessary use. On 4/8/26, a house-wide audit of all residents receiving PRN psychotropic medications was completed. All findings were corrected in collaboration with the provider. On 4/9/2026, the Psychotropic Medication Policy was reviewed, and a tracking tool was implemented. Licensed nursing staff received reeducation on appropriate use; policies were reinforced to require complete PRN order component, including clear indication, upon initiation and review of medication. The Director of Nursing/designee will complete by auditing new psychotropic medication orders weekly following the Interdisciplinary Team (IDT) meeting to ensure checklist and policy are utilized. Weekly audits will take place for one month and monthly thereafter for 3 months. Results will be reviewed at QA meetings until compliance is achieved.	04/21/2026

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

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F0605 SS = D	Continued from page 4 §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure instructions for use of multiple as-needed (PRN) psychotropic medications were included, to ensure appropriate administration and minimize the risk of unnecessary medication usage for 1 of 5 residents (R43) reviewed for unnecessary medications. Findings include: R43's quarterly MDS dated 2/4/26, indicated R43 had both long-term and short-term memory impairment and severely impaired cognitive decision-making skills. The	F0605		

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F0605 SS = D	Continued from page 5 MDS indicated R43 had Alzheimer's disease, anxiety, depression, and a "psychotic disorder". The MDS indicated R43 did not have hallucinations, delusions, or rejection of care during the look-back period. R43's care plan dated 2/5/26, indicated R43 had an alteration in mood "or" behavioral expression as well as dementia with psychotic features. The care plan indicated R43's target behaviors were paranoia, beliefs that weren't real, anger at caregivers and family, physical aggression, and wandering/yelling in the hall at others or things that aren't there. The care plan indicated R43 used anticonvulsant medication, including gabapentin and Depakote, with the target behaviors of complaints of pain with completion of activities of daily living (ADLs) and refusal to complete ADLs. The care plan did not give instructions regarding PRN psychotropic medication use, such as the order of administration. R43's Order Summary Report dated 3/4/26 included: - An order dated 3/12/26 for .5 milligrams (mg) of lorazepam (an anti-anxiety medication) twice daily as needed for agitation and psychosis. - An order dated 3/4/26 for 125 mg of delayed-release Depakote sprinkles (an anticonvulsant medication sometimes used for mood stabilization) daily as needed for agitation. - The order summary included no further instructions on which medication should be given first, for what symptoms these symptoms should be given, etc. R43's medication administration record (MAR) dated 3/1/26 to 3/19/26 at 9:17 a.m., indicated R43 had received the PRN Depakote eight times and the PRN lorazepam documented as administered four times and once on 3/15/26 at 8:33 p.m., with an administration code of "9" meaning other/see nursing notes. R43's administration progress note dated 3/15/26 at 8:33 p.m., included a note, "agitation". During an interview on 3/19/26 at 9:49 a.m., LPN-A confirmed he was R43's nurse and had worked with her previously. LPN-A stated R43 had a lot of restlessness and agitation, and that is when he would administer the PRN lorazepam or Depakote. LPN-A stated he had used both the PRN lorazepam and Depakote and had found the lorazepam more helpful. LPN-A stated he was unsure what medication he was supposed to try first if the resident had agitation, so he would just pick one of them.	F0605		

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F0605 SS = D	Continued from page 6 During an interview on 3/19/26 at 11:58 a.m., RN-B confirmed she had reviewed the orders and did not see any instructions for administration for the PRN psychotropic medications, such as which medication staff should administer first if agitation was observed. During an interview on 3/20/26 at 7:52 a.m., the director of nursing (DON) stated she would expect the pharmacist to review antipsychotic medications during their monthly reviews to ensure they had an appropriate diagnosis. The DON stated that if a resident had multiple PRN medications written for agitation, the interdisciplinary team (IDT) would need to meet, and they would need to come up with a plan with further instructions for when each medication should be administered. The facility's Psychotropic Medication Use policy dated 3/2025, indicated psychotropic medications were only to be used when the medication was appropriate to treat a resident's specific, diagnosed, and documented condition. The policy did not include instructions for management of multiple (non-antipsychotic) PRN psychotropic medications.	F0605		
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F0636	The facility has completed the PHQ-9 and BIMS assessments for the affected resident and updated the plan of care to reflect the resident's status and needs; however, the MDS cannot be corrected retrospectively and will remain as submitted in accordance with coding guidelines. A facility wide audit of MDS assessments completed within the last 90 days was conducted to identify any additional incomplete assessments, and any identified issues were addressed. The facility reeducated the MDS coordinator and interdisciplinary Team on comprehensive assessment requirements and implemented an MDS tracking system along with routine review of upcoming Assessment Reference Dates (ARDs), to ensure timely completion of required sections. The Director of Nursing or Designee will monitor compliance through weekly audits for four weeks, followed by monthly audits for two months, with results reviewed through the QAPI process to ensure sustained compliance.	04/24/2026

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F0636 SS = D	Continued from page 7 (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.	F0636		

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F0636 SS = D	Continued from page 8 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure complete and comprehensive Minimum Data Set(s) (MDS) were completed for 1 of 5 residents (R4) reviewed for assessment accuracy. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2025, identified the MDS as an assessment tool that facilities are required to use. The manual directed comprehensive assessments, "include the completion of both the MDS and the CAA process, as well as care planning." The CMS RAI manual also identified that the RAI process (i.e., MDS) was completed to help evaluate residents' strengths and areas for care planning. R4's annual MDS dated 2/13/26, included the following information: -Section B- Hearing, Speech, and Vision: indicated B0100 (Persistent vegetative state/no discernible consciousness) was answered as no, so staff were to continue to B0200, Hearing. B0200-B1000, fields regarding R4's hearing, speech, his ability to understand and make himself understood, and vision, were dashed. -Section C- Cognitive Patterns: indicated C0100 (Should Brief Interview for Mental Status (C0200–C0500) be Conducted?) was answered as yes, so staff were to continue to C0200. Sections C0200 through C1310, fields regarding mental status, memory, cognitive skills, and signs of delirium were dashed. -Section D- Mood: indicated D0100 (Should Resident Mood Interview be Conducted?) was answered yes, so staff were to continue to D0150. D0150 questions A-I, an interview assessing the resident's mood, were dashed, and D0160 had a score entered of 99, which indicated that the interview was unable to be completed. D0500-D0600, the section for staff assessment of resident mood was left blank. -Section F-Preferences for Customary Routine and Activities: indicated F0300 (Should Interview for Daily and Activity Preferences be Conducted?) was coded as yes, continue to F0400. Section F0400 A-H, an interview for daily preferences, was all dashed. Section F0800, the staff assessment of daily and activity preferences was left blank.	F0636		

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F0636 SS = D	Continued from page 9 During an interview on 3/19/26 at 10:28 a.m., registered nurse (RN)-C, the MDS coordinator, stated she had received an email from the nursing team that they had missed completing parts of the MDS assessment for R4, such as mood, cognition, and social assessment, before the assessment reference date (ARD). RN-C stated that by the time she looked for the assessments to use to complete the MDS, it was past the ARD. RN-C stated she hadn't noticed until it was too late to complete the assessments, so she had dashed the areas for which she could not find an assessment. During an interview on 3/20/26 at 7:49 a.m., the director of nursing (DON) stated that the floor nurses completed the MDS assessments, and then the unit managers were in charge of ensuring MDS assessments were completed and completed accurately. The facility's Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care planning, and Submission policy dated 3/2025, indicated the facility's multidisciplinary team would work together to complete the MDS assessment according to the RAI manual.	F0636		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., facial hair removal) was provided for 1 of 1 resident (R39) reviewed who was dependent of staff for activities of daily living (ADLs). Findings included: R39's quarterly Minimum Data Set (MDS) dated 2/17/26, indicated R39 had severe cognitive impairment, did not refuse personal cares, and needed setup/cleaning assistance with oral hygiene and personal hygiene. MDS also indicated R39 needed moderate assistance with bathing, dressing, and toileting hygiene. R39's Medical Diagnoses report dated 3/20/26, indicated diagnoses of chronic diastolic heart failure, amnesia,	F0677	The Facility corrected the deficient practice by immediately providing facial hair removal for the identified resident and updating the care plan to reflect grooming needs and preferences. A review of all residents' dependent on staff for ADL was conducted to ensure personal hygiene needs are met, with and concerns addressed promptly. Staff were reeducated on providing and documenting routine ADL care including grooming. Household Coordinator will monitor compliance through weekly audits for 4 weeks, and monthly audits for 3 months. Results will be reviewed at QA meetings.	04/22/2026

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F0677 SS = D	Continued from page 10 essential hypertension, muscle weakness, and bilateral shoulder pain. R39's care plan dated 3/20/26 indicated R39 was cognitively impaired and was had difficulty in communicating. This care plan indicated the staff will anticipate and meet her needs. R39's care plan also indicated she had self-care performance deficits and needed assistance of one staff member with dressing, grooming and hygiene. During observation on 3/17/26 at 12:33 p.m., R39 had facial hair on her chin. R39 had about 12 beard strands, each measuring approximately 4 to 5 centimeters long. During the interview, R39 raised her shoulders in response to multiple questions including how she felt about the strands on her chin. During interview on 3/18/26 at 9:10 a.m., registered nurse (RN)-D verified R39 facial hair strands. RN-D stated the nursing assistants needed to help her shave. During interview on 3/18/26 at 1:45 p.m., RN-B stated resident needed to be shaved on shower day or during morning cares. RN-B stated, sometimes R39 got agitated during personal cares and wondered if R39 would let the staff shave her. RN-B verified there was nothing documented on R39's care plan about refusing shaving. During interview on 3/19/26 at 11:33 a.m., nursing assistant (NA)-B stated she will shave female residents' facial hair, unless their care plan indicated the female resident didn't want to be shaved. NA-B stated, "It's not okay for a woman to have facial hair." During interview on 3/23/26 at 9:54 a.m., resident representative (RR)-B returned call placed on 3/18/26 at 9:45 am. RR-B indicated on 3/22/26, the previous day, he saw a razor in R39's room and the staff shaved R39 and "she looked nicer." RR-B stated it would be important for his mother to not have long facial hair. During interview on 3/20/26 at 8:10 a.m., the director of nursing (DON) stated female facial hair needed to be shaved and added "It's a dignity issue." Facility policy titled Resident Care Policy dated 7/2024, indicated every resident will have morning and bedtime cares done daily and shave residents per planned individual preferences.	F0677		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F0686	On 3/25/26, the resident identified with redness from a CPAP machine was assessed, treatment plan was updated,	04/21/2026

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F0686 SS = D	Continued from page 11 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed, determine or develop proactive interventions to help address pressure injury risk and prevent skin alteration worsening, after a pressure-induced skin alteration was identified for 1 of 3 residents (R19) reviewed for pressure injuries. Findings include: R19's annual Minimum Data Set (MDS) dated 12/19/25, indicated R19 had intact cognition, no rejection of care behaviors, and was diagnosed with heart failure, kidney failure, and diabetes. The MDS indicated R19 had a functional limitation in range of motion to both upper extremities, needed moderate assistance with toileting hygiene, was dependent for bathing, and needed moderate assistance for bed mobility. The MDS indicated R19 was at risk for pressure ulcers and had no current pressure ulcers. R19's order summary dated 6/9/25, included an order dated 6/9/25 to place R19's "CPAP or BiPAP on at bedtime", check overnight, remove in the morning, clean the tubing, and fill the chamber with water before use. R19's care plan dated 12/22/25, indicated staff were to inspect R19's skin for redness, open areas, scratches, cuts, or bruises while providing care and report changes. The care plan indicated R19 was at risk for skin impairment, and the nurse was to be notified "immediately" of any new areas of skin breakdown. The	F0686	Continued from page 11 and care plan was updated. On 3/28/26, daily monitoring was initiated for resident's face until healed. On 3/25/26, a house-wide audit of residents at risk for pressure ulcers from CPAP machines was completed. No more deficiencies were identified. On 4/9/26, the Skin Integrity Management Policy was reviewed and determined to be appropriate. Licensed nursing staff and RAs educated on prevention of alteration of skin integrity regarding CPAP machines, reporting on skin integrity, and documentation of skin integrity. The Director of Nursing/designee will monitor compliance through weekly body audit review for residents with CPAP machines for one month and monthly times 3 months. Results will be reviewed at QA meetings.	

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F0686 SS = D	Continued from page 12 care plan indicated R19 required assistance from staff with repositioning and toileting, and staff were to wash his skin with mild soap, rinse, and dry thoroughly while providing care. The care plan indicated that staff were to assist R19 in applying his CPAP machine per MD/NP orders. R19's medication/treatment administration record dated 3/1/26 to 3/18/26 at 8:00 a.m., indicated R19's CPAP/BiPAP had been applied every night and removed every morning during the period. R19's progress note dated 3/6/26 at 1:51 p.m., indicated that R19's body audit indicated his skin was "clean, dry, and intact." R19's progress note dated 3/16/26 at 4:50 p.m., indicated a bowel, bladder, skin risk summary and analysis were completed, and that his skin remained intact. R19's progress notes dated 3/6/26 to 3/16/26 were reviewed with no note of the redness or scabbing under R19's eyes. During an interview and observation on 3/17/26 at 10:52 a.m., R19 was observed in his room in his wheelchair. Under R19's right eye, a skin alteration was observed in the wrinkle that ran from his undereye diagonally down, following the curve of the nose to his mouth. In this wrinkle, R19 had redness that was about 2.5 centimeters (cm) long by one cm wide, with a dark red scab about the length and thinness of the end of the nail of an adult thumb. R19 stated he had some drainage from the scab and thought the drainage started about a week ago. R19 was unable to further describe the drainage. R19 stated he thought the skin alteration was from the CPAP machine he wore at nighttime. R19 stated the redness caused slight pain, but not enough to stop using the machine. On 3/18/26 at 10:44 a.m., he thought he had had the skin redness and scab under his right eye for about three weeks to a month. R19 was observed with the same skin alteration on the right side as described above, although the skin redness was now about one cm by one cm. R19 also had new redness in the mirrored wrinkle on the left side of the face, which extended approximately 4 cm long with a width of approximately one cm. During an interview and observation on 3/18/26 at 10:58 a.m., registered nurse (RN)-A stated he was the nurse in charge of R19's care today, but normally worked on a different unit, so he was not that familiar with R19's	F0686		

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F0686 SS = D	Continued from page 13 care. RN-A was observed to assess R19's skin and confirmed the above measurements from 3/18/26. RN-A was observed to press on the redness, the skin turning white, and then turning red again. RN-A stated he thought R19's CPAP mask might be too tight, causing the facial redness and scabbing. R19 stated he was unsure how long R19 had had the scab and redness on his face, but thought it was caused by pressure from his CPAP mask. RN-A was observed to apply a CPAP mask to R19. The mask was observed to sit on top of the skin alterations. RN-A stated the aides should report when the resident has skin alterations like this one, but it had not been reported to him, and he was unsure if it had been in the past. RN-A stated he was going to notify the provider of the skin alteration to determine what treatments or methods needed to be utilized to prevent the skin alteration from worsening. During an interview on 3/18/26 at 11:06 a.m., nursing assistant (NA)-A stated R19 had a pattern of redness and scabbing under his eyes from his CPAP machine that would heal and then recur, and this the redness and scabbing under his right eye had been there for about a week to a week and a half. NA-A stated she had noticed that the scab under his right eye had been bleeding slightly when she took the machine off him at around 8 a.m. this morning. NA-A stated she thought she had told licensed practical nurse (LPN)-A about the wound previously, but thought he should know about it anyway because anyone going into his room could see it. During an interview on 3/19/26 at 9:42 a.m., LPN-A stated he had worked with R19 in the last week, but did not recall if he had scabbing or redness under his eyes, but did not think that was something he noticed. LPN-A stated he was unsure if any NAs had notified him of any skin alterations for R19 in the last couple of weeks, but thought he would have added a progress note about the skin alteration if he had. During an interview on 3/19/26 at 11:49 a.m., the nurse manager for the unit, RN-B, stated she had not been notified of the redness and scabbing on R19's face prior to the surveyor questioning the staff about the skin alteration, but she would have expected the staff to. RN-B stated that now that she had been made aware of the issue, she had assessed the CPAP mask, and it appeared as if staff had been unvelcroing the straps that adhere the mask to the face instead of using the clips that allow the mask to be detached from the face without altering the strap length. RN-B stated she had refitted the mask to R19, as it was previously too tight, and was completing education with her staff to ensure the clips were used instead of the straps to	F0686		

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F0686 SS = D	Continued from page 14 prevent worsening of R19's skin alterations that were caused by the pressure of R19's CPAP mask. During an interview on 3/20/26 at 7:56 a.m., the director of nursing (DON) stated that if an aide noticed a skin alteration, they should notify the nurse, who should document this occurrence so it can be fully assessed, and a treatment plan can be developed. The facility's Skin Integrity Management policy dated 10/2025, indicated a pressure ulcer/injury referred to a localized damage to the skin or underlying soft tissue usually over a bony prominence or related to a medical or other device. The policy indicated that staff were to inspect the skin for signs or symptoms of breakdown and inspect the skin under medical devices every shift. The policy indicated that body audits were to be performed weekly, and the findings were to be documented.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure safety measure were put in place to prevent accidents for one of two resident (R25) reviewed for accidents who had known fainting episodes, often while on the toilet. Findings include: R25's quarterly minimum data set (MDS), dated 12/30/25, indicated R25 was admitted to the care facility on 7/26/23 and was cognitively intact. The MDS further indicated R25 required substantial to maximum assistance with dressing, bathing and toileting. During an interview on 3/17 and 10:09 a.m., R25's	F0689	Immediate action was taken to ensure safety for the identified resident, including reassessment of fainting-related risks, updating the care plan to require staff presence during toileting, and re-educating involved staff. The facility conducted a review of all residents with fainting disorders or similar conditions to ensure appropriate supervision interventions were in place, and care plans were revised as needed. To prevent recurrence, the facility reinforced policies requiring continuous supervision for residents with seizure activity during toileting and provided facility-wide education to nursing staff and CNAs on fainting and or seizure safety and adequate supervision expectations. Ongoing compliance will be monitored through routine audits and observations by nursing leadership, with findings reviewed through the QAPI process and corrective actions implemented as necessary to sustain compliance	04/21/2026

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F0689 SS = D	Continued from page 15 family member (FM)-A stated she had concerns about R25 being left alone in the bathroom due to her having multiple "fainting episodes" while on the toilet, stating she believes she had an episode most recently on 3/1/26 while on the toilet. FM-A stated they were not sure what was causing the fainting episodes, but the facility was aware she was having them. R25's care plan, lacked any mention of R25's fainting spells to include interventions for her safety or interventions for staff to take during or after a fainting spell. R25's Orders, dated 7/29/25, contained an order for DNR (do not resuscitate), "do not transfer to ER (emergency room) for fainting episode less than 15 minutes. Call family immediately." R25's progress note, dated 12/30/25, indicated R25 had a "fainting episode" while sitting on the toilet and had a drop of blood coming from her mouth from possibly biting her tongue or cheek. R25's progress note, dated 11/12/25, indicated R25 "passed out" while being transferred from the toilet to her bed via a stand lift. During an interview on 3/18/26 at 9:36 a.m., nursing assistant (NA)-E stated R25 transferred via an easy stand and staff had to "pretty much do everything for her." NA-E stated R25 has had three fainting spells in the past year that she was aware of, stating R25 will be on the toilet and "just kind of tip over" but that she could be left in the bathroom alone and would use the call light when she was done. During an interview on 3/19/26 at approximately 7:30 a.m., registered nurse (RN)-F stated she did not often work with R25 and she was not aware of any fainting spells but that R25 was able to be left alone in the bathroom. During an interview on 3/19/26 at approximately 11:30 a.m., clinical coordinator and registered nurse (RN)-E stated she was aware of R25's fainting spells and the thought was she maybe having vasovagal episode (a common, usually harmless, faint caused by an overactive nervous system, leading to a sudden drop in heart rate and blood pressure which can be caused when straining to defecate) but the family has also brought up concerns of possible seizures. CC-A stated the episodes seemed to mostly happen when she was on the toilet and that she did not feel R25 was safe to be left alone on the toilet. CC-A confirmed these episodes or safety precautions to not leave R25 alone on the toilet were not care planned or ordered and they should have been. During an interview on 3/20/26 at 8:10 a.m., the director of nursing (DON) stated she was aware of R25 having "one or two" fainting episodes on the toilet but was under the impression most of the episodes happened at night while R25 was in bed. The DON stated there should be something in place to protect R25 during the fainting episodes.	F0689		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning	F0695	On 3/25/26, the resident identified was evaluated and	04/21/2026

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F0695 SS = D	Continued from page 16 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure residents using a continuous positive airway pressure (CPAP) machine had appropriate orders for use to include equipment settings for 1 of 2 residents (R19) reviewed for respiratory care. Findings include: R19's annual Minimum Data Set (MDS) dated 12/19/25, indicated R19 had intact cognition, no rejection of care behaviors, and was diagnosed with heart failure, kidney failure, and diabetes. The MDS indicated R19 had a functional limitation in range of motion to both upper extremities, needed moderate assistance with toileting hygiene, was dependent for bathing, and needed moderate assistance for bed mobility. R19's care plan dated 12/22/25, indicated that staff were to assist R19 in applying his CPAP machine per MD/NP orders. R19's order summary dated 3/17/26, included multiple orders for weekly and daily cleaning and maintenance of R19's CPAP/BiPAP machine. The order summary included an order dated 6/9/25, to place R19's "CPAP or BiPAP on at bedtime", check overnight, remove in the morning, clean the tubing, and fill the chamber with water before use. The order summary did not include equipment settings. R19's medication/treatment administration record dated 3/1/26 to 3/18/26 at 8:00 a.m., indicated R19's CPAP/BiPAP had been applied every night and removed every morning during the period. During an interview and observation on 3/17/26 at 10:52 a.m., R19 was observed in his room in his wheelchair with a ResMed Airsense 10 CPAP machine on his bedside table. R19 stated he wore his CPAP machine at night and had since prior to being admitted to the facility.	F0695	Continued from page 16 orders obtained to include settings and care plan updated. On 3/25/26, a house-wide audit of all residents receiving respiratory care was completed. All findings were corrected. On 4/9/26, the Respiratory Care Policy was reviewed. Education was completed by 4/15/26 for licensed nurses on respiratory care and documentation. The Director of Nursing/designee will monitor compliance through weekly audits for 4 weeks and monthly audits for 3 months. Results will be reviewed at QA meetings.	

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F0695 SS = D	Continued from page 17 During an interview and observation on 3/18/26 at 10:58 a.m., registered nurse (RN)-A stated he was unsure what R19's CPAP settings were, as the machines came preset and the nursing staff just started the machine every night for the resident. RN-A stated he was unsure where the settings would be documented but thought they should be found somewhere in R19's medical record. During an interview on 3/19/26 at 11:49 a.m., the nurse manager for the unit, RN-B, stated R19 had entered the facility with the CPAP machine and was unsure if they had any record of the settings, but did not think they did. RN-B stated she would review the medical record and provide the order for the settings if she found it. No order for settings was received. During an interview on 3/20/26 at 7:56 a.m., the director of nursing (DON) stated that usually, residents were admitted from the hospital or the community and already had their CPAP machine with preset settings. The DON stated that she would expect these orders to be to be a part of a resident's medical record. The facility's CPAP and BiPAP Management policy dated 1/2023, indicated that staff should review the care plan and the physician's orders "if required," but did not give further instructions as to what these orders should include.	F0695		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F0756	The affected resident psychotropic medications were reviewed immediately by the medical provider and the consulting pharmacist to ensure appropriate diagnosis and diagnosis and indication for use. A review of all residents on psychotropic medications was completed to confirm valid diagnosis and documentation. On 4/9/26, the Psychotropic Medication Management Policy was reviewed and remains appropriate. The facility reinforced the pharmacist drug regimen review process to ensure irregularities are identified and addressed in a timely manner. Appropriate staff have been reeducated on psychotropic medications process and documentation. The Director of Nursing/designee will monitor compliance by tracking 100% of pharmacy recommendations for 3 months. Additionally, audits to be completed for new antipsychotic medication orders weekly following daily interdisciplinary (IDT) meetings to ensure proper diagnosis. Findings will be reviewed through QAPI to ensure continued compliance	04/21/2026

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F0756 SS = D	Continued from page 18 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified and acted upon 1 of 5 residents (R5) reviewed who had psychotropic medications without an adequate medical diagnosis for ongoing use. Findings include: R5's quarterly Minimum Data Set (MDS) dated 12/31/25, indicated R5 had severely impaired cognition and was diagnosed with dementia and depression. The MDS indicated R5 did not have hallucinations, delusions, or rejection of care during the look-back period. R5's Medical Diagnosis summary dated 4/14/25, included a diagnosis of dementia with "other behavioral disturbance" dated 4/14/25, depression, a cognitive communication deficit, and an additional diagnosis dated 6/25/21 for dementia without behavioral/psychotic/mood disturbance or anxiety. R5's care plan dated 10/31/25, indicated R5 received antipsychotic medication for dementia with behavioral disturbance. The care plan indicated R5's 6.25 mg of Seroquel two times a day had been decreased to once a day at bedtime on 9/19/24. The care plan indicated that the benefits of the medication outweighed the risks of	F0756		

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F0756 SS = D	Continued from page 19 it use. The care plan included target behaviors of crying and talking about needing to get out. The antipsychotic medication use care plan's latest revision was 10/31/25. R5's Provider's Orders form dated 2/12/26, indicated R5 had an order to restart 6.25 milligrams (mg) of Seroquel (an antipsychotic medication) daily at 2 p.m. for a diagnosis of "sundowning" (a group of symptoms someone with dementia may experience as the sun sets). R5's provider progress note dated 2/12/26 at 12 a.m., indicated R5 had a diagnosis of vascular dementia, had "sundowning association", and used Seroquel 6.25 mg every evening. The note indicated that after the provider had previously planned to discontinue the medication, they had talked with nursing staff and learned that the resident's "sundowning" started at 2 p.m. every day, and the resident became exit-seeking and wanted to call the police. The provider changed the time of the order to 2 p.m. R5's Pharmacy progress note dated 2/26/26 at 12:17 p.m., indicated R5's medication regimen had been reviewed by the pharmacist, and no irregularities had been identified, and no recommendations were being made. R5's Order Summary dated 3/18/26, included an order dated 2/12/26 for 6.25 mg of Seroquel daily at 2 pm for "sundowning". During an interview on 3/19/26 at 9:53 a.m., licensed practical nurse (LPN)-A confirmed he was R5's nurse for the day and worked with her frequently. LPN-A stated, when asked what R5's use of Seroquel, that there were times when R5 would get "a little agitated," so she received the medication, but was unsure of any further medical diagnosis for the use of Seroquel. During an interview on 3/19/26 at 12:01 p.m., the nurse manager for the unit, registered nurse (RN)-B, stated she had not realized that the Seroquel had been ordered for sundowning and thought it was "weird". RN-B stated she would contact the provider and request that the order be changed to include an appropriate diagnosis. During an interview on 3/20/26 at 7:34 a.m., the CP, stated the pharmacist who usually covered this facility was on leave, but he had worked with the facility previously. The CP stated that when he would review a resident's medications and the resident was on an antipsychotic medication, he would ensure the medication had an appropriate diagnosis. The CP stated	F0756		

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F0756 SS = D	Continued from page 20 that if he had noticed that R5 had an order for Seroquel for sundowning, he would have sent a letter to the provider to double-check that the medication had an appropriate diagnosis. During an interview on 3/20/26 at 7:52 a.m., the director of nursing (DON) stated she would expect the pharmacist to review antipsychotic medications during their monthly reviews to ensure they had an appropriate diagnosis. The facility's Psychotropic Medication Use policy dated 11/2024 indicated the consultant pharmacist would review the resident's medical record for any irregularities, and these would be reported to the director of nursing services and the attending physician to be acted upon.	F0756		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were administered at the ordered time resulting in worsened pain for 1 of 1 resident (R25) resulting in a significant medication error. Findings include: R25's quarterly minimum data set (MDS), dated 12/30/25, indicated R25 was admitted to the care facility on 7/26/23, was cognitively intact, and required substantial to maximum assistance with dressing, bathing and toileting. The MDS further indicated R25 received scheduled and as needed pain medication with a pain rating of 7/10 in the past five days. The national library of medicine reports that withdrawal symptoms from baclofen can start within hours of a missed dose to include rebound muscle spasticity and painful spasms. R25' s orders, printed 3/20/26, indicated R25 was receiving the following medications:Baclofen (muscle relaxant used to treat spasticity, specifically spasms, cramping, and tightness) 7.5 milligrams (mg) three times a day at 7:30 a.m., 1:00 p.m., and 6:00 p.m., for muscle spasms	F0760	On 3/17/26, the identified staff (TMA) was placed on administrative leave. Corrective action was completed on 3/19/26 and shadowing completed with a peer upon return to work. The identified resident was immediately assessed by the Licensed Nurse to determine any adverse effects related to the delayed medication administration. Nursing staff were re educated on the importance of timely medication administration in accordance with physician orders and facility policy, including prioritization of time sensitive medications. The Medication Administration Record (MAR) system and medication pass schedules were reviewed and adjusted as indicated to support timely administration. The Director of Nursing or designee will conduct medication pass observations and audits weekly for four (4) weeks, then monthly thereafter, to ensure compliance with medication administration times. Any variances will be addressed through immediate corrective action and additional staff training as needed. The Director of Nursing is responsible for ongoing monitoring to ensure sustained compliance with this regulation	04/21/2026

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F0760 SS = D	Continued from page 21 and 2.5 mg two times a day as needed for muscle spasms.Give AM meds around 7:30 a.m.R25's medication administration record (MAR), dated 3/1/26 - 3/19/26, indicated R25 rated her pain as 5/10 or higher on 30 shifts (recorded three times a day) and received as needed oxycodone for 9/10 pain on two occasions. R25's care plan, dated 8/14/23, indicated R25 was at risk for pain related to osteoarthritis, neuralgia and neuritis, and lumbar radiculopathy. During interview and observation on 3/17/26 at 10:00 a.m., R25 and family member (FM)-A were sitting in R25's room. FM-A stated R25 had frequent back pain and received Tylenol and baclofen three times a day for pain. FM-A voiced concerns about morning medications repeatedly being administered to R25 late, passed 11 a.m., and stated R25 was scheduled to receive her medications at 7:30 a.m. FM-A stated when medication administration was late, it caused R25 pain. R25 confirmed, stating she was in pain currently. R25 was also displaying visible signs of pain to include restlessness and facial grimacing. By 10:55 a.m., R25 had still not received her morning medications despite them being ordered for 7:30 a.m., administration. During interview on 3/17/26 at 10:58 a.m., trained medication assistant (TMA)-A stated she had not yet administered R25's 7:30 a.m., medications because she was waiting on the nurse to get R25's AREDS 2 (a vitamin for eye health). During an interview on 3/19/26 at 8:10 a.m., TMA-B stated when a specific time is identified for medication administration for a resident, it is expected the medication be given within one hour before and one hour after the specified time. TMA-A confirmed R25's morning medications were ordered to be given at 7:30 a.m. During an interview on 3/19/26 at approximately 11:30 a.m., registered nurse and clinical coordinator (RN)-E stated it would be expected that R25's medications be administered at 7:30 a.m., stating it was concerning that R25's morning medication were being administered past 11:00 a.m. RN-E stated they were aware of the TMA who struggled to administer R25's medication timely. During an interview on 3/20/26 at 8:10 a.m., the director of nursing (DON) stated R25 receiving her morning medication at 11:00 a.m. was an issue and it was expected that medication be administered timely, stating if an exact time for medication was ordered (i.e. 7:30 a.m.) it was expected to be followed. The DON stated R25 was expected to receive her 7:30 a.m. medications at that ordered time to help keep her comfortable. A facility policy, titled Medication Administration Policy, dated 5/2021, indicated the 8 rights of drug administration will be followed when administering all medication, including right time.	F0760		
F0880	Infection Prevention & Control	F0880	On 3/19/26, staff identified not following proper	04/23/2026

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F0880 SS = D	Continued from page 22 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.	F0880	Continued from page 22 protocol for standard precautions and hand washing were educated immediately. Facility reviewed the Infection Control Policy, and it remains appropriate. All staff have been reeducated on hand hygiene, and Enhanced Barrier Precaution practices. The Infection Preventionist and Director of Nursing/designee will monitor compliance by completing 4 audits weekly for 4 weeks, and monthly audits for 3 months. Results will be reviewed at QA meetings.	

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F0880 SS = D	Continued from page 23 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 3 of 6 residents (R26, R51, R4) and failed to perform hand hygiene to reduce the risk of the spread of infection to others for 1 of 6 residents (R51) reviewed for infection control practices. Findings include: R26 R26’s annual Minimum Data Set (MDS) dated 12/3/25 identified R26 had intact cognition and was dependent on staff for all personal cares including transfers. R26’s diagnoses include obstructive uropathy (blockage preventing normal urine flow) and used an indwelling catheter (tube from bladder to a bag outside the body to drain urine). R26’s physician orders (PO) dated 1/6/2026 stated “Enhanced Barrier Precautions due to catheter. Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting”.	F0880		

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F0880 SS = D	Continued from page 24 R26's care plan dated 4/12/24 included, "I require enhanced barrier precautions due to an indwelling medical device". During observation on 3/16/26 at 7:32 p.m., R26's door to the hallway had an Enhanced Barrier Precautions sign attached and a personal protective equipment (PPE) cart was outside the room. During observation and interview on 3/17/26 at 7:47 a.m., nursing assistant (NA)-A combed R26's hair, repositioned her in her wheelchair, and then picked up R26's large urine drainage bag and attached it to the underside of her wheelchair. During this time NA-A did not wear a PPE gown. NA-A stated R26 was on EBP due to her coccyx wound and not the presence of a Foley catheter bag. NA-A stated she wore a PPE gown and surgical mask only when performing any type of perineal (genital area) care. During observation and interview on 3/18/26 at 11:03 a.m., NA-D entered R26's room with portable blood pressure monitor and thermometer unit and obtained blood pressure and temperature of R26 and then exited room after removing gloves and sanitizing unit. NA-D verified he did not wear a PPE gown or mask. NA-D stated, "we only wear a gown when we change [R26] because of her wounds on her back and catheter." R51 R51's annual MDS dated 12/31/25 identified intact cognition and dependence on staff for all hygiene and personal cares. R51 had diagnoses of multiple sclerosis, neurogenic bladder and quadriplegia (paralysis of both arms and legs), and used an indwelling catheter (suprapubic catheter). R51's physician orders (PO) dated 1/6/2026 stated "Enhanced Barrier Precautions due to catheter. Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting". R51's care plan dated 4/12/24 state, "I require enhanced barrier precautions due to an indwelling medical device". During continuous observation and interview on 3/17/26 from 10:51 a.m. to 11:40 a.m., NA-A and NA-B entered R51's room to transfer R51 from bed to wheelchair using a Hoyer lift (medical device that transfers a person	F0880		

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F0880 SS = D	Continued from page 25 from bed to chair and back again). Both were wearing gloves, PPE gown, and mask. NA-A and NA-B turned R51 from his back to his right-side laying hands on him. NA-B applied ointment to R51's buttock and then both NA-A and NA-B turned R51 back onto his back. NA-B then trimmed an abdominal pad to place around the stoma (opening in the abdomen where the urine drains into a bag). NA-B did not perform hand hygiene or change gloves during this process. NA-A applied an alcohol wipe to exit port of the catheter prior to emptying the urine into a graduated cylinder. NA-A emptied urine into the container and then applied a second alcohol wipe to the exit port. During this time, NA-A did not change her gloves or perform hand hygiene. Both aides assisted R51 to wheelchair using a sling and then adjusted his posture, clothes, and catheter bag once he was in the wheelchair. Upon exiting the room NA-B stated expectation to change gloves, "every time I go from one body part to another". NA-B stated she could not recall if she changed her gloves from R51's buttock ointment application to the suprapubic catheter site. NA-A also stated they did not recall changing gloves or performing hand hygiene before emptying R51's catheter. During observation on 3/18/26 at 11:26 a.m., an unidentified staff member went into R51's room to answer a call light. R51 stated he wanted a drink of water. The unidentified staff member did not sanitize or wash hands upon entering R51's room. The unidentified staff member provided water and left the room after sanitizing hands. R51 stated there were times when staff failed to wear a PPE gown when emptying his catheter. During interview with director of nursing (DON) on 3/18/26 at 12:52 p.m., DON stated expectation, "of all staff to wash or sanitize their hands prior to entering [any] resident room and on exit." DON stated, "EBP is a weakness for us", and stated any time a staff member touched a resident who was in EBP they should be wearing a PPE gown, mask and gloves. She stated handling a catheter without wearing a PPE gown "is not acceptable", and staff needed to know what direct patient contact means. DON also stated any time a staff member adjusted or assisted with moving a resident in their wheelchair they should be wearing a PPE gown, gloves and mask. In addition, "staff must change gloves when providing cares from one area of the body to another". R4 R4's annual Minimum Data Set (MDS) dated 2/13/26, indicated R4 had an indwelling urinary catheter and was	F0880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 26 diagnosed with hypertension and diabetes. R4's Order Summary dated 3/19/26, indicated R4 utilized an indwelling urinary catheter, and catheter care was to be completed every shift. The order summary indicated R4 was on enhanced barrier precautions due to a catheter, so staff were to utilize gloves and gowns during high-contact resident care activities, including dressing, transferring, changing linens, providing hygiene, etc. During an interview and observation on 3/19/26 at 8:14 a.m., licensed practical nurse (LPN)-A was observed completing hand hygiene, applying gloves, and entering R4's room. LPN-A was not observed to put on a gown. A sign indicating R4 was on enhanced barrier precautions was observed on her door, and R4 was observed lying in bed. LPN-A approached R4, asked for her name and date of birth, then used a lancet to draw blood from one of R4's fingers. LPN-A then used a glucometer to take R4's blood sugar reading. LPN-A then uncovered R4's stomach, leaning over her bed with his legs leaning against her covers. LPN-A then administered insulin (an injection used to lower blood sugar) into R4's stomach. LPN-A then removed his gloves and completed hand hygiene. R4 asks to be boosted up in bed, so LPN-A (not wearing any gloves or a gown) leaned over R4's bed, legs touching her bed, grabbed a sheet on the bed that was underneath R4, and attempted to boost her up in bed. When asked when a gown and gloves should be worn when a resident was on enhanced barrier precautions, LPN-A stated that it only needed to be worn when changing wounds or working with the catheter. Undated facility policy titled Infection Control Standard Precautions Facility policy titled CC Enhanced Barrier Precautions modified April 2025, identified EBP (targeted gowns and gloves) are used in conjunction with standard precautions and will be implemented during high contact resident care activities which include, "When caring for residents with wounds or indwelling medical devices". In addition: 4. When performing high-contact resident care activities staff should: a. Perform hand hygiene b. Don gloves and a gown c. Complete the high-contact activity	F0880		

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F0880 SS = D	Continued from page 27 d. Remove gloves and gown and dispose of in a trash can in the resident's room or if outside of the resident's room (e.g., shower/tub room or therapy gym) in a trash can contained within the area. e. Perform hand hygiene.	F0880		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 03/17/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Flagstone was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K0000		04/15/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245312	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - FLAGSTONE B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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K0000	Continued from page 1 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Flagstone is a 5-story building with a basement. The building was constructed in 2020 and was determined to be of Type II(222) construction. The skilled nursing home is located on the first two floors, with assisted living on floors three and four and a memory care unit on the fifth floor. The facility is fully protected throughout by an automatic fire sprinkler system. In addition, the building has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms monitored for automatic fire department notification. The facility has a capacity of 72 beds and had a census of 70 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities	K0324	On 3/19/2026 ansul inspection report was received by Environmental Service Director (ESD) from inspection date from February 2026. Report has been added to ansul inspection binder. Inspection is loaded in as a task in the TELS system. Process has been put in place to set an outlook reminder to verify inspection reports have	04/16/2026

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K0324 SS = F	Continued from page 2 Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, 19.3.2.5.3(9), NFAP 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2, 11.2.1. This deficient finding could have a widespread impact on the residents within the facility. On 03/17/2026 at 10:34 AM, it was revealed by a review of available documentation that the most current range hood suppression system documentation was dated 11/14/2024. An interview with the Regional Engineering Manager and the Environmental Services Director verified this deficient finding at the time of discovery.	K0324	Continued from page 2 been received 15 days after inspection has occurred. Environmental Service Director (ESD) is responsible for corrective actions and monitoring of compliance. Corrective date was 3/20/2026	
K0346 SS = F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than four hours in a 24 hour period, the authority	K0346	On 3/18/2026 the Fire Alarm out of service policy was updated to include contact information for the Deputy State Fire Marshal to be contacted in the event the fire alarm is out of service. Contact information will be verified for accuracy in the annual Emergency Preparedness review. Findings of the annual review to be reported in QAPI. ESD will be responsible for corrective actions and monitoring of compliance.	04/16/2026

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K0346 SS = F	Continued from page 3 having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. On 03/17/2026at 09:57 AM it was revealed by a review of available documentation that the fire alarm out-of-service policy that was provided at the time of the survey did not have contact information for the Deputy State Fire Marshal that shall be contacted in the event the fire alarm is out of service. An interview with the Regional Engineering Manager and The Environmental Services Director verified this deficient finding at the time of discovery.	K0346	Continued from page 3 Corrective date 3/18/2026	
K0354 SS = F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and	K0354	On 3/18/2026 the Fire Sprinkler out of service policy was updated to include contact information for the Deputy State Fire Marshal to be contacted in the event the sprinkler system is out of service. Contact information will be verified for accuracy in the annual Emergency Preparedness review. Findings of the annual review to be reported in QAPI. ESD will be responsible for corrective actions and monitoring of compliance. Corrective date 3/18/2026	04/16/2026

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K0354 SS = F	Continued from page 4 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. On 03/17/2026 at 09:57, it was revealed by a review of available documentation that the fire sprinkler system out-of-service policy that was provided at the time of the survey did not have contact information for the Deputy State Fire Marshal that shall be contacted in the event the fire sprinkler system is out of service. An interview with the Regional Engineering Manager, and the Environmental Services Director verified this deficient finding at the time of discovery.	K0354		
K0372 SS = E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. On 03/17/2026 at 11:20 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors in Starring Lake caused by a cable. An interview with the Regional Engineering Manager and The Environmental Services Director verified this	K0372	On 4/13/2026 the penetrations in the smoke barrier located on 1st floor starring lake west above the fire doors were sealed with fire caulking. To prevent reoccurrence vendors and IT will be educated upon job completion to notify ESD of any penetration occurring to building. ESD will complete walk through with vendor following any hired project. Environmental Service Director (ESD) is responsible for corrective actions and monitoring of compliance. Corrective date 4/13/2026.	04/16/2026

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K0372 SS = E	Continued from page 5 deficient finding at the time of discovery.	K0372		
K0918 SS = F Bldg. 02	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 generators 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 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. On 03/17/2026 at 10:48 AM, it was revealed by a review of available documentation that at the time of the survey, the facility was unable to provide documentation confirming that the emergency generator	K0918	Upon investigation of records, generator monthly testing did not occur in November, January, and February. Generator load testing was completed on 3/24/2026. New ESD was hired on 3/2/2026 and has been trained on this monthly task. The task will be recorded in the TELS work order system monthly. Campus Administration and ESD will review monthly tasks for anything outstanding during monthly 1:1 meetings. Environmental Service Director (ESD) is responsible for corrective actions and monitoring of compliance. Corrective date 3/24/2026.	04/16/2026

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K0918 SS = F Bldg. 02	Continued from page 6 was tested in November 2025. An interview with the Regional Engineering Manager and The Environmental Services Director verified this deficient finding at the time of discovery.	K0918		