STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING **01 - MAIN BUILD...** B. WING	**04/07/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947**

(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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/07/2026. At the time of this survey, LA CRESCENT HEALTH SERVICES found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/19/2026

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: 245319	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947**

(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
K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. LA CRESCENT HEALTH SERVICES is a 1 story building with no basement. The original building was constructed in 1968, one-story with no basement, and was determined to be of Type II (000) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K0000		05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245319	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 19.7.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/07/2026 between 10:00 AM and 12:00 PM, it was revealed by a review of available documentation, that documentation presented for review exhibited patterning of dates and times of fire drills. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712	No specific resident was identified. All residents, staff, and visitors have the potential to be affected. Executive Director, or designee, re-educated Maintenance Director regarding Fire Drill policy and procedure and to ensure that fire drills are conducted with proper randomness on 05/07/2026. Maintenance Director adjusted times and dates for the remainder of the year to ensure randomization of fire drills on 4/29/26. The Executive Director, or designee, will complete an audit weekly for 5 weeks to ensure that compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K0353	No specific resident was identified. All residents, staff, and visitors have the potential to be affected. Executive Director, or designee, educated Maintenance Director regarding Sprinkler System policy on 05/07/2026. A monthly TELS has been entered into the Maintenance Director's Monthly Job board by Executive staff. Maintenance Director contacted Ahern, and Ahern is set to replace the sprinkler head on the date of 05/11/2026. The Executive Director, or designee, will complete	05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245319	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947**

(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
K0353 SS = D Bldg. 01	Continued from page 3 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.2(5). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/07/2026 at 11:30 AM, it was revealed by observation that sprinkler head(s) located in the Kitchen exhibited debris loading. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	Continued from page 3 audit weekly for 5 weeks to ensure that compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

May 4, 2026

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: CCN: 486728900
Cycle Start Date: April 14, 2026

Dear Administrator:

On April 14, 2026, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both **substandard quality of care** and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On April 13, 2026, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 19, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 19, 2026, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 19, 2026, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 14, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or

§483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, La Crescent Health Services is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 14, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

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

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 14, 2026, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an

explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 4, 2026

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

Re: State Nursing Home Licensing Orders
Event ID: 1F3549-H1

Dear Administrator:

The above facility survey was completed on April 14, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947**

(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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/6/26 through 4/14/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed:	20000		05/19/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947**

(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
20000	Continued from page 1 H53195940C (255111746 and 2739638) and H53191098C (247735426). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		05/19/2026
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member	20265	Corrected.	05/19/2026

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20265	Continued from page 2 of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to notify 1 of 1 resident's (R5) representative (also the Power of Attorney) when R5 was sent to the emergency department after a fall, and for repeated refusals of care upon her return to the facility. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional	20265		05/19/2026

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20265	Continued from page 3 urinary incontinence but was always continent of bowel. During a record review, R5's dismissal summary from the 2/12/26 hospitalization; the hospital physician stated, "R5 is unable to receive and evaluate information effectively and communicate decisions necessary to manager her health. I recommend that the provisions contained in her Power of Attorney for Health Care be activated". During a record review, R5's POA was activated at the facility upon return from the 2/12/26 hospitalization. R5's care plan failed to address R5's refusals of care; additionally, the care plan failed to provide direction, so staff know when to notify provider and POA about refusals of care and medications. R5's orders failed to address R5's refusals of care; additionally, the orders lacked direction, so staff knew when to notify the medical providers and POA about refusals of care and medications. During record review, R5 refused medications or treatment on the following dates after the POA was activated: -3/6/26: refusal to have blood drawn, no POA notification -4/6/26: refused weight measurements, no POA notification -4/7/26 at 5:16 a.m.: refused constipation medication, no POA notification -4/7/26 at 12:22 p.m.: refused constipation medication, no POA notification -4/7/26 at 8:58 p.m.: R5 stated her pain was worse, no POA notification -4/8/26 at 4:58 a.m.: R5 stated her pain had gotten worse, refused all bowel medications, no POA notifications During record review, there was no documentation R5's POA had been notified prior to leaving the	20265		05/19/2026

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20265	Continued from page 4 facility to go to the Emergency Room (ER) on 2/12/26 after suffering a fall at the facility. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's POA was activated when she returned from the hospital on 2/22/26. DON stated the POA was activated when R5 was in the hospital because R5 had increasing periods of confusion and lack of understanding about her medical status. DON confirmed R5 has been intermittently refusing cares or treatments since the beginning of February. DON stated the facility doesn't notify the POA of refusals, probably should if the resident doesn't understand her condition or how the meds work. DON stated it is important to notify the POA about refusal of cares and treatments, so the POA knows the treatments R5 is or isn't receiving. Attempted phone call to speak with R5 POA made on 4/7/26 at 10:45 a.m. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated she was aware R5 had intermittently been refusing medications. PA-A stated she would expect to be notified of ongoing refusals. PA-A stated R5 did not have an order to notify facility providers or POA of refusals of cares or treatments. PA-A stated notification to the POA is important, so the POA understands what treatments R5 isn't getting and why. Additionally, the POA may have some influence with R5 and encourage R5 to accept the cares and treatments. A facility policy titled Change in Condition of the Resident dated 9/20/2022, the facility should immediately inform the resident representative when there is a need to alter treatment or a need to discontinue an existing treatment due to adverse consequences, or to commence a new form of treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures regarding notification of change of condition. The DON or designee could educate all appropriate staff on the policies and procedure on notification of change of condition. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results of monitoring to the	20265		05/19/2026

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20265	Continued from page 5 facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		05/19/2026
20270	Use of Oxygen CFR(s): MN Rule 4658.0090 A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to standards of care to prevent respiratory infections for 1 of 1 residents (R16) who required oxygen for chronic respiratory failure with hypoxia (a condition where the lungs are unable to adequately oxygenate the blood). Findings include: R16's quarterly Minimum Data Set (MDS) assessment, dated 2/11/26, identified R15 had intact cognition with no hallucinations, delusions, or rejection of care with admission date of 11/21/25. R16's admission record indicated on 2/18/26, R16's primary diagnosis was end stage renal disease with secondary diagnoses of chronic respiratory failure with hypoxia, biventricular heart failure (heart not working correctly), dependency on supplemental oxygen, unspecified right bundle-branch block (condition where electrical conduction in the heart is impaired), thoracis aortic ectasia (dilation or bulging in aorta in the chest), and atrial fibrillation (heart not beating correctly). Additional secondary diagnosis, dated 1/21/25, included: pulmonary hypertension (high blood pressure in the arteries of the lungs that strains the heart), and pleural effusion (buildup of excess fluid between the layers of the pleura surrounding the lungs). During an interview on 4/6/26 at 4:08 p.m., R16 was observed to be sitting in his wheelchair receiving oxygen via nasal canula from an oxygen concentrator at 2 liters(l)/minute. R16's oxygen tubing did not have a date or label on it. R16 was observed to have a portable oxygen tank on the	20270	Corrected.	05/19/2026

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20270	Continued from page 6 back of his wheelchair with the oxygen tubing with nasal cannula attached wrapped around it with no date on it. R16 was not sure when the oxygen tubing had been changed. R16's care plan, printed 4/7/26, identified R16 was at risk for respiratory impairment related to chronic respiratory failure with hypoxia with an intervention to administer oxygen per MD orders. The care plan lacked any indication on how often the oxygen tubing should be changed or who would be responsible for changing the oxygen tubing. R16's Order Summary Report, dated 4/6/26, included the following orders: -"2L continuous oxygen via nasal cannula. Concentrator and cylinders with contents and regulators" with a start date of 2/18/26. The Order Summary Report lacked evidence of an order to change oxygen tubing. R16's medication and treatment administration record (MAR/TAR) for 4/1/26 to 4/14/26 included the following orders: -change oxygen tubing and humidifier bottles weekly. Date tubing in the afternoon every Thursday with a start date of 4/16/26. - Change oxygen tubing and humidifier bottles weekly. Date tubing as needed for visibly soiled or known contamination with a start date of 4/9/26. This order had a start date after survey entrance. -Oxygen at 2L/minute via nasal cannula every shift with a start date of 4/9/26 R16's Medication Administration Record and Treatment Administration Record (MAR/TAR) for March 2026 was reviewed and lacked any order for oxygen use or changing of oxygen tubing or oxygen supplies. R16's task log was reviewed and did not include any change of oxygen tubing. R16's progress notes from 3/1/26 through 4/7/26, made no mention of any oxygen tubing having been changed by staff.	20270		05/19/2026

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20270	Continued from page 7 Observation and interview ON 4/7/26 at 8:29 a.m., of R16 identified he was observed sitting in his room in his wheelchair and reported he just got done eating. R16's oxygen tubing from the oxygen tank on the back of the chair was observed to be partially on the floor with no date on it. R16's oxygen tubing from the concentrator, which R16 was observed wearing, did not have a date on it. R16 stated the facility will change the tubing when it "doesn't fit" but couldn't explain what that meant or when the last time the tubing was changed. At 12:17 p.m., R16 was observed in the dining room for lunch. R16 was observed to have oxygen on via nasal cannula from his portable tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/8/26 at 9:55 a.m., R16 was observed to be leaving the facility. R16 was observed to have nasal cannula on and receiving oxygen from portable oxygen tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/9/26 at 2:53 p.m., R16 was observed propelling self in wheelchair in his room. R16 was observed receiving oxygen via nasal cannula from the portable tank located on the back of his wheelchair. The oxygen tubing, including the nasal cannula, from the oxygen concentrator was noted to be laying in a box on the floor. Neither oxygen tubing was dated or labeled. R16 stated he was unsure when the oxygen tubing was last changed. During an interview on 4/9/26 at 2:54 p.m., NA-C stated they are familiar with R16. Staff put oxygen on and off residents including R16. NA-C stated nursing assistants do not change oxygen tubing. NA-C observed R16's oxygen tubing and verified the set of oxygen tubing (from the oxygen tank or oxygen concentrator) was dated or labeled. NA-C stated they are unsure when it was last changed as it was not dated. During an interview on 4/10/26 at 12:54 p.m., nursing assistant (NA)-A stated they do not change the oxygen tubing for residents. Staff only turn the oxygen on and off and do not adjust any settings. NA-A thought it was the nurse's responsibility to change the tubing as nurse aides have never changed oxygen tubing.	20270		05/19/2026

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20270	Continued from page 8 During an interview on 4/10/26 at 1:03 p.m., registered nurse (RN)-A stated oxygen tubing and supplies should be changed weekly to prevent infections and the nurses are responsible for this. During an interview and document review on 4/10/26 at 1:04 p.m., RN-C stated oxygen tubing should be changed weekly, and nurses were responsible for ensuring that was completed. RN-C stated there would be an order to change the oxygen tubing. RN-C stated it was expected to date and label the oxygen tubing also. RN-C reviewed R16's medical record and verified the order to change R16's oxygen tubing was entered on 4/9/16 (after survey entrance) and there was no previous order. RN-C stated it was important to change oxygen tubing to prevent infection and prevent build up in the nasal cannula. During an interview on 4/10/26 at 3:21 p.m., the assistant director of nursing (ADON) stated the expectation was oxygen tubing was changed weekly for infection control purposes as not changing it can contribute to respiratory illnesses. The expectation would be for tubing and all supplies to be dated and labeled. The ADON verified there were no additional nursing or physician's orders prior to 4/9/26, to change R16's oxygen tubing or humidifier bottles and there should have been. On 4/14/26 at 9:53 a.m., the director of nursing (DON) stated the expectation would be oxygen tubing would be changed weekly and as needed to help decrease risk of infection as not changing it can put a resident more at risk for infection. This was to be documented on the MAR/TAR. Review of the current, undated Northwest Respiratory Services instruction sheet for oxygen use the facility used for direction for staff, identified staff were to change tubing every month and the nasal cannula every week. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents' oxygen tubing is changed and dated routinely. The DON or designee could educate all appropriate staff on the policies and procedures	20270		05/19/2026

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20270	Continued from page 9 and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20270		05/19/2026
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement a person-centered care plan for 1 of 1 resident (R5) reviewed for comprehensive care plans. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's hospital discharge summary dated 2/25/26 noted the following: -Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air	20555	Corrected.	05/19/2026

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20555	Continued from page 10 -Skin problem to left heel: clean, dry, intact: treatment offloading and open to air -Skin problem to right heel: clean, dry, intact: treatment open to air R5's current, undated care plan indicated the following: urinary incontinence: report changes in skin integrity found during daily care potential for pressure ulcer development: administer treatments as ordered, and monitor effectiveness follow facility policies/protocols for the prevention/treatment of skin breakdown monitor nutritional status monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth) The need for a feeding tube/potential complications from that tube. R5 was to have no complications from the feeding tube. Staff were to administer formula and hydration and flushes per order. R5's care plan lacked identification of skin breakdown on R5's coccyx; further lacking goals and interventions for monitoring, treating, and documenting R5's actual skin breakdown. Additionally, R5's care plan lacked identification of R5's refusal of cares and treatments; further lacking goals and interventions to apply when R5 refused cares and treatments. R5's care plan lacked identification of R5's risk for fluid-volume imbalances; further lacking goals and interventions for monitoring, treating and documentation. R5's care plan lacked specific time requirements to elevate the head of the bed (HOB) to 30-45 degrees during and after tube feeding. Lastly, R5's care plan lacked specific symptoms and side effects of hypercalcemia, hypothyroidism, and hyperparathyroidism. R5's February, March, and April 2026 treatment administration record (TAR) noted to "Monitor	20555		05/19/2026

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20555	Continued from page 11 Mepilex dressing to buttock daily and change every 3 days and as needed when soiled" beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 is a complicated resident due to her multiple medical problems including hypercalcemia, hypothyroidism, hyperparathyroidism, nausea, vomiting, and gastrectomy tube (g-tube) a device surgically inserted through the belly directly into the stomach to deliver nutrition, fluids, and medications). PA-A stated she would expect to see a care plan for each of these areas. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5 had a Stage I pressure ulcer; her care plan did not reflect any goals or interventions to care for and prevent worsening of the pressure ulcer. DON confirmed R5's care plan only indicated a risk for pressure ulcers; should have identified the actual Stage I pressure ulcer and contain interventions such as encouraging position changes, how often to monitor the coccyx, and treatment directions. The DON stated R5's care plan did not include information about her refusal of cares and treatments. The DON stated this care plan would identify the interventions that could have worked to encourage R5 to follow care and treatment orders. The DON stated R5 did not have a fluid-volume care plan. This care plan would be beneficial so staff could monitor and document fluids; this would be important for the resident since she had a G-tube. The DON stated this resident is complicated, R5's care plan should probably have more detail about her medical conditions so staff could be aware of the symptoms or side effects. The DON stated a complete and comprehensive care plan is important so facility staff could identify, monitor, and treat R5's medical issues. During an interview on 4/8/26 at 2:39 p.m., PA-A stated she would expect a complete and comprehensive care plan; a comprehensive care plan allows the facility to adjust cares and interventions based on R5's needs and desire for treatment. PA-A stated she would specifically expect to see a care plan for skin breakdown, fluid intake-output, refusals of care, and tube feeding	20555		05/19/2026

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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
20555	Continued from page 12 care. PA-A stated care plans are important because they can be tied into the treatment and medication tasks the facility staff perform; without a specific care plan, staff might not know how to provide specific types of care. A facility policy titled Comprehensive Care Plan dated 9/23/2022, the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. These objectives will be used to monitor the residents' progress. Alternative interventions will be documented, as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		05/19/2026
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to prevent complications	20875	Corrected.	05/19/2026

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20875	Continued from page 13 of enteral feeding and failed to provide appropriate treatment and services for 1 of 1 resident (R5) reviewed who required tube feedings and medication administration through a gastrostomy tube (g-tube). This failure created the likelihood of serious harm for R5, including worsening symptoms of nausea and vomiting, and additional hospital visits. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5 was admitted to the facility on 1/16/26 with an admission diagnosis of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). A review of R5's medical record identified the following hospitalizations/emergency room visits identified on: 1) 2/12/26: R5 was sent to the hospital after a fall with decrease cognition and returned to the facility on 2/22/26; the primary diagnosis was hypercalcemia. R'5 Power of Attorney (POA) was activated during this hospital visit and thereafter due to ongoing intermittent confusion. Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 2/6/26 at 11:31 p.m.: stated she was sick to her stomach, the record lacked provider notification 2/7/26 at 5:13 p.m.: declined oral medication, she did not wish to take them, the record lacked provider notification	20875		05/19/2026

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20875	Continued from page 14 2/7/26 at 10:54 p.m., stated she was feeling nauseous and “just can’t take them,” referring to her medications, which she refused. The record lacked provider notification 2/9/26 at 3:30 p.m.: R5 took her medications through her g-tube but vomited shortly after administration, record lacked provider notification 2/11/26 at 2:07 p.m.: R5 refused all medications stating, her “stomach can’t handle it.” 2/12/26 at 10:13 a.m., sent to emergency room 2) 3/6/26: R5 was sent to the hospital as a result of increased nausea and vomiting and returned to the facility on 3/10/26; the primary diagnosis was hypercalcemia. Record review of R5’s progress notes indicated the following concerns prior to being sent to emergency room: 3/1/26 at 12:33 p.m.: R5’s g-tube was flushed and R5 reported feeling nauseous after flush 3/2/26 at 10:46 a.m.: R5’s g-tube was flushed and R5 reported feeling nauseous after flush 3/3/26 at 2:28 p.m., in-person visit with physician assistant (PA)-A, discussed R5’s ongoing nausea, no new orders written 3/4/26 at 5:28 p.m., notified by hospital team the calcium level is high from recent blood draw, increase cinacalcet to 90 mg, stop vitamin D, push fluids, and repeat calcium level on 3/6/26 3/6/26 at 12:56 p.m.: R5 vomiting again, instruction to send to emergency room 3/10/26 at 4:55 p.m.: POA remains activated 3) 4/6/26: R5 was sent to the emergency room as a result of increased abdominal pain and returned to the facility on 4/6/26; the primary diagnosis was pleural effusion (collection of fluid around your lungs.) Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 3/17/26 6:06 p.m.: R5 experienced nausea and vomiting, no record of provider or POA notification 3/29/26 at 12:07 p.m.: R5 experienced nausea and vomiting after morning medications, no record of	20875		05/19/2026

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20875	Continued from page 15 provider or POA notification 3/30/26 at 12:13 p.m.: R5 experienced nausea and vomiting after morning medications, no record of provider or POA notification 3/31/26 at 3:40 p.m.: R5 experienced nausea and vomiting after medications, no record of provider or POA notification 4/5/26 at 12:00 p.m.: R5 experienced right-sided abdominal pain that continues until 4/6/26 at 12:00 p.m., ongoing nausea, vomiting, pain; resident sent to emergency room 4) 4/8/26: R5 was sent to the hospital and returned to the facility on 4/9/26; the primary diagnosis was right-sided pneumonia (acute inflammation of the lung caused by an infection, commonly caused by aspiration.). Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 4/6/26 at 6:00 p.m.: returned from emergency room, R5 was noted to "have a heavy stool burden", R5 refused laxatives, no record of provider or POA notification 4/7/26 at 5:16 a.m.: R5 refused laxatives, no record of provider or POA notification 4/7/26 at 12:22 p.m.: R5 refused laxatives, no record of provider or POA notification 4/7/26 at 8:58 p.m.: R5 stated her upper right quadrant pain is worse, no record of provider or POA notification 4/8/26 at 12:15 p.m.: R5 received daily medications and 150 ml water flush while positioned less than 30 degrees 4/8/26 at 12:42 p.m.: R5 experienced nausea and increased right upper quadrant pain 4/8/26 at 2:38 p.m.: R5 experienced nausea and vomiting after receiving 60 ml of the 150 ml water flush, did not proceed with entire amount due to vomiting, R5's care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order	20875		05/19/2026

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20875	Continued from page 16 -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. Additionally, the care plan lacked assessment and interventions for the risk of fluid volume deficits. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily	20875		05/19/2026

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20875	Continued from page 17 During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 has a complicated gastrointestinal (GI) tract. R5 has hyperparathyroidism and this is the source of her hypercalcemia. R5 is no longer a surgical candidate to have her parathyroid removed, symptom management has been the primary direction of care. PA-A stated electrolyte imbalances will be an ongoing concern for R5. PA-A stated she is unsure how often the nutrition team is working with R5 or how involved they are with her care. According to the American Society for Parenteral and Enteral Nutrition article, “Medication via Enteral Feeding Tubes: A Clinician's Guide”, located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities. During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5’s morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 20ml instead of the ordered 15ml.	20875		05/19/2026

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20875	Continued from page 18 Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. At time of administration, RN-A failed to ensure the head of the bed was 30-45 degrees, with the bed remaining at approximately 10 degrees and R5 slouched down in the bed. RN-A stated R5 received a 30ml water flush before medication administration, 30ml water flush in between each medication, and a 150ml water flush at the end of the medication administration. During medication administration, RN-A diluted each medication with approximately 2ml of water, which failed to dilute the medication enough to allow it to pass through the g-tube. When RN-A put the medication into the barrel of syringe attached to the g-tube, the medication was not diluted enough to flow, RN-A then begun adding additional unmeasured amounts of water and continued to add until the medication would flow; 2 medications required pressure from the syringe plunger to flow through the g-tube. During medication administration process, R5 stated she was having increased nausea and abdominal pain. RN-A failed to recognize R5 was still not at the correct position. During administration RN-A failed to flush the g-tube between medications levothyroxine and metoprolol. RN-A was unsure what effect this could have on R5. After administration was completed, RN-A failed to set the head of the bed up to 30-45 degrees; bed remained at approximately 10 degrees with R5 slouched down in bed. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she was unsure how much additional water she had added to dilute medication enough to flow through R5’s g-tube; she guessed it was approximately 5ml. RN-A stated with the complete medication administration and water flushes; R5 had received approximately 450 ml of liquid. RN-A stated she had not had g-tube education for “some time.” RN-A stated the facility had not had a resident that required tube feedings or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had	20875		05/19/2026

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20875	Continued from page 19 been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. When R5 returned to the facility on 3/10/26 her calcium level was 9.5. PA-A stated she expected facility staff to know the basic signs and symptoms of hypercalcemia, including mental status changes, nausea, vomiting, and constipation. PA-A stated she expected the nursing team to follow the standard of practice when administering medication via g-tube, including sitting the head of bed at 30-45 degrees during and after tube feeding and medication administration. Additionally, she was unsure of the amount of water needed to dilute the medication; however, she would anticipate this to be approximately 5-10 ml of water, and the nurse should be keeping track of this to adjust the water flushes during administration. PA-A stated she relies on the pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During observation on 04/08/2026 at 3:09 PM, emergency services arrived at the facility to take R5 to the emergency room; RN-A stated R5 had been experiencing worsening nausea and vomiting and abdominal pain. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. PA-B stated she had included a statement in her discharge summary that stated, “We have asked the staff at your skilled nursing facility (SNF) receive additional education on management of your feeding tube.” PA-B stated she included this statement because R5 had told her she felt the staff at the facility did not know how to use her g-tube. PA-B stated she would expect the facility providers to manage the calcium levels after discharge. PA-B expected the head of the bed to be elevated to 30-45 degrees during and after tube feedings and medication administration. PA-B stated medication interactions should be managed by the facility provider and pharmacist. PA-B stated medication administration times should be assessed by the facility provider and pharmacist. PA-B stated medications given with other medications or around tube feedings can have side effects for R5 that include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. PA-B stated mismanagement of the g-tube with both tube feedings and medication	20875		05/19/2026

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20875	Continued from page 20 administration could result in complications for R5. These complications could include harm, injury, and in worst case, death. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. PH-A stated R5 should be in an upright position during tube feedings and medication administration and up to an hour afterwards. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Additionally, levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. PH-A stated the medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission. During an interview on 4/9/26 at 11:22 a.m., licensed practical nurse (LPN)-B stated R5 had frequent nausea and vomiting. LPN-B stated they only track R5's bowel movements for output. LPN-B stated R5's emesis are not documented in R5's medical record. LPN-B described the process of administering medications via g-tube which did not include elevating head of bed during or after administration of medications or enteral feedings. During an interview on 4/9/26 at 11:42 a.m., registered nurse (RN)-B stated R5 was admitted to her unit at the hospital yesterday evening. Upon arrival at the hospital unit, R5 was nauseous and vomiting. R5 was given medication to resolve these symptoms. RN-B stated she had given R5 her normal medications this morning. RN-B stated the resident has not experienced nausea or vomiting since yesterday. RN-B stated R5 was able to take sips of water or clear liquids without experiencing nausea or vomiting. RN-B stated the resident must be sitting at least 30–45-degree angle during tube feeding and medication administration. RN-B stated if R5 receives tube feeding when not at the correct angle,	20875		05/19/2026

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20875	Continued from page 21 she is at risk for nausea, vomiting, and abdominal pain. Additionally, she would be at a high risk for aspiration or aspiration pneumonia. During an interview on 04/09/2026 at 11:54 AM, PA-C stated frequently monitoring of calcium should be complete weekly until R5's calcium levels are stable, then monthly, then every six months. R5 has been on cinacalcet to manage her high calcium levels; she is on a consistent dose, but ongoing monitoring should still be weekly to bi-weekly. PA-C stated the most common symptoms of hypercalcemia included altered mental status, muscle cramps, and constipation. Nausea and vomiting aren't necessarily a symptom of hypercalcemia; but they are symptoms of the cinacalcet. PA-C stated if R5 was having nausea and vomiting, there is probably another cause for her symptoms. PA-C stated she would expect the facility staff to know the signs and symptoms of hypercalcemia, medication side effects, and how to properly manage the g-tube during tube feedings and medication administration. PA-C stated if R5's g-tube was mismanaged, R5 could be at risk for harm, increasing symptoms of nausea and vomiting and abdominal pain. Additionally, improper positioning during tube feeding and medication administration could result in serious risk for aspiration or other complications. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions; the pharmacy providing the medication will go through the interaction checker; the interaction warnings then get placed on the medication and the medication is delivered to the facility. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing.	20875		05/19/2026

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20875	Continued from page 22 During an interview on 4/7/26 at 3:15 p.m., vice president of success (VPS)-A stated nurses were educated about g-tubes annually and for regular competencies. VPS-A stated nurses can receive g-tube education sporadically; they didn't believe nursing staff were educated about the needs of R5 prior to her arrival. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated she believed the facility provided education to staff about g-tubes but couldn't find the specific education. DON stated she would expect education to be given for g-tubes, tube feeding administration, medication administration, g-tube complications, and g-tube side effects or symptoms. DON stated the facility had not cared for a resident with a g-tube in about a year. DON stated, generally g-tube education is annually, she did not provide g-tube education to staff about this R5 and her specific needs. DON stated it would have been beneficial to have educated staff specifically about R5 so staff could be prepared for any complications. On 4/14/26 at 10:22 a.m., a call was placed to the facility Medical Director; no return call received. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration. A facility policy titled Enhanced Barrier Precautions (EBP) dated 8/8/25, high-contact resident care activities include device care or use: feeding tubes. EBP should be followed when performing high-contact resident care activities. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. A facility policy titled Medical Director Responsibilities dated 4/22/25, the medical director's responsibilities include implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on	20875		05/19/2026

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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
20875	Continued from page 23 diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care. A Facility Assessment dated 7/11/25, training and skills unique to resident population: our nurses are trained in enteral feedings; our facility not only conducts a skill assessment during floor orientation of nurses and nursing assistants but also conducts monthly competencies of various skills to ensure that annual training occurs to keep skills honed.	20875		05/19/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to monitor and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 1 of 1 resident (R5) reviewed for pressure ulcers. Findings Include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate	20900	Corrected.	05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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20900	Continued from page 24 assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). R5's hospital discharge summary dated 2/25/26 noted the following: -Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air -Skin problem to left heel: clean, dry, intact: treatment offloading and open to air -Skin problem to right heel: clean, dry, intact: treatment open to air R5's care plan indicated the following: -urinary incontinence: report changes in skin integrity found during daily care -potential for pressure ulcer development: -administer treatments as ordered, and monitor effectiveness -follow facility policies/protocols for the prevention/treatment of skin breakdown -monitor nutritional status -monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound	20900		05/19/2026

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20900	Continued from page 25 size (length x width x depth) R5's care plan lacked resident-specific interventions to prevent or mitigate pressure ulcers that included reposition changes, specialty pressure redistribution boots for heels, toileting program to prevent wet skin, specialty padding for chairs, and barrier protection creams. R5's February, March, and April 2026 treatment administration record (TAR) noted to "Monitor Mepilex dressing to buttock daily and change every 3 days and as needed when soiled" beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. R5's weekly skin assessments were completed 1/23/26, 1/30/26, 2/7/26, 3/3/26, 3/27/26, and 4/3/26, stating no skin issues. The weekly skin assessments failed to identify R5's coccyx stage I pressure injury, ongoing monitoring, and ongoing assessments. During an interview on 4/7/26 at 11:31 a.m., R5 stated she does have breakdown on her buttocks. R5 stated the staff at the facility put a covering over it every few days; sometimes it gets wet when she is incontinent, so they must replace it then too. R5 is unsure if the skin breakdown is better or worse because she can't see it. Sometimes her buttocks and her heels get sore; but she doesn't get up much so that won't change much. R5 doesn't remember if facility staff have asked her to reposition herself or offered to assist her to reposition. R5 prefers to sit up because she gets nauseous a lot. During an observation and interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated she was not aware R5 had any skin breakdown on her coccyx and awas unaware of fragile skin on her heels. PA-A and the director of nursing (DON) evaluated R5's coccyx, PA-A stated this was a stage I pressure ulcer. Additionally, the mepilex dressing on the coccyx was not placed correctly to prevent further skin breakdown. PA-A stated she would expect to see a pressure ulcer care plan with interventions to prevent further breakdown.	20900		05/19/2026

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20900	Continued from page 26 During an interview on 4/7/26 at 12:02 p.m., DON stated R5 came back from the hospital in February with a stage I pressure ulcer. DON stated the facility ordered the mepilex for her coccyx, but she acknowledged the facility did not update the care plan or TAR to include interventions to prevent or mitigate skin breakdown. DON was unaware about the fragile skin on her heels; acknowledged R5 should have had interventions in place to prevent pressure injuries of her heels. During a follow up interview on 4/7/26 at 3:25 p.m., DON stated R5's care plan was appropriate when she first arrived in January; but should have been updated upon her return in February to include interventions to prevent or mitigate skin breakdown. DON confirmed R5 had a current stage I pressure ulcer. Additionally, the DON confirmed the facility had not been assessing the coccyx weekly since 3/4/26. The DON stated it is important to implement a complete resident-specific care plan to prevent additional skin breakdown and alterations. A facility policy titled Pressure Injuries and Non-Pressure Injuries dated 7/20/22, the facility will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for	20900		05/19/2026

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20900	Continued from page 27 further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		05/19/2026
20930	Rehab - Nasogastric, Gastrostomy tubes CFR(s): MN Rule 4658.0525 Subp. 7 B. Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to monitor daily oral intake and daily output; additionally, the facility failed to develop a system to monitor and assess daily intake and output for 1 of 1 resident (R5) reviewed who required nutritional and hydration support via a gastrostomy tube (g-tube). Findings Include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 required hydration and nutrition via a feeding tube (g-tube). R5’s current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing) requiring the placement of a gastrostomy tube (g-tube) for nutrition and medication administration. R5’s care plan dated 1/26/26 indicated R5 required tube feeding, hydration, and flushes per order, check tube placement prior to meds and feedings, elevating head of bed 30-45 degrees, care of tube per orders, and report signs of aspiration or intolerance of	20930	Corrected.	05/19/2026

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20930	Continued from page 28 feeding. R5's care plan lacked identification for a risk in decreased hydration, lacked the specific signs and symptoms of aspiration, lacked resident-specific interventions to mitigate complications when using the g-tube, and lacked guidance and collaboration for monitoring fluid balance and imbalance. R5's current physician orders included tube feedings (Vital Advanced Formula at 100 milliliters (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150ml of water flush in g-tube after medication administration for the AM medication pass. R5's orders lacked a clear monitoring system for intake and output including urine output, emesis amounts, amount of bowel movement, and amount of oral intake. R5's nutrition assessments dated 1/22/26, 3/2/26, and 3/16/26: section 30 failed to accurately identify how much oral intake the resident received (to adjust free water amounts), section 36 failed to identify gastrointestinal (GI) concerns such as nausea and vomiting, and section 44 failed to identify the amount of emesis the resident experienced (to know when to adjust free water amounts). R5's electronic medical record lacked collaboration, assessments, and outcome about who would be overseeing and managing daily intake and output in relation to the amount of tube feeding and free water flushes R5 should have received to maintain adequate fluid and nutrition. Additionally, the medical record and testing lacked collaboration and follow up to monitor and assess previously known electrolyte imbalances (high calcium, low potassium, high sodium) with a previously low Albumin level of 3.0 (could indicate malnutrition) on 1/6/26. During an interview on 4/7/26 at 11:31 a.m., R5 stated they give her a lot of water during the day and then in the evening they start her tube feedings; she thinks "it is just too much liquid for [her] to handle", and she gets nauseous and vomits at times. R5 stated she wasn't sure who kept track of all that liquid going in, but she felt like it was too much.	20930		05/19/2026

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20930	Continued from page 29 During observation and interview on 4/7/26 at 11:47 p.m., physician assistant (PA)-A had entered R5's room to evaluate her pressure ulcer; upon entering, the resident was vomiting and handed the emesis bag to the nurse. The emesis bag contained approximately 300ml of vomit; a later record review noted this amount was not documented in a treatment administration record (TAR) nor a progress note. Additionally, the TAR and task list did not contain an option to document any output. PA-A stated R5's GI tract was complicated due to her hyperparathyroidism resulting in high calcium levels; symptom management is the primary treatment option as R5 is no longer a surgical candidate. She was "not aware how often nutrition is involved with her care". She was not actively monitoring daily intake and output. She stated she also did not have any laboratory orders for blood draws to assess electrolyte imbalances; "the teams in the hospital might be managing that." During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's tube feeding care plan should have been more resident-specific to include aspects of care such as head-of-bed elevation, medication administration, g-tube complications, and symptoms and side effects. The DON acknowledged they should have been monitoring R5's intake and output more closely, especially the emesis amounts. Fluid balance is important for R5 since she is receiving tube feedings and free water flushes. Staff needed to make sure her hydration and nutrition are adequate. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for the proper care and to ensure the safe administration of enteral nutrition according to professional standards of practice. Nursing staff could be educated as necessary to the importance of safe administration of enteral feeding to avoid complications and/or infections. The DON or designee could audit nursing staff assigned to residents effected and take that information to the quality assurance performance improvement (QAPI) to ensure compliance and determine the need for further	20930		05/19/2026

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20930	Continued from page 30 education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20930		05/19/2026
20960	Dietary Service - Food Quality CFR(s): MN Rule 4658.0600 Subp. 1 Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 4 of 4 residents (R1, R10, R15, and R30) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchen. Findings include: R1’s quarterly Minimum Data Set (MDS) dated 3/12/26, identified R1 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was independent with eating. During an interview on 4/6/26 at 2:56 p.m., R1 stated the food is cold and he must send it back a lot, it doesn’t matter if he eats in the dining hall or his room; the food is always cold. The facility had the hardest time keeping eggs, mashed potatoes, and beans warm. He stated he has told them so many times and, no one ever does anything about it. During an observation on 4/7/26 at 8:13 a.m., R1 was observed in the dining hall tasting his food (French toast), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R10’s comprehensive Minimum Data Set (MDS) dated 2/10/26, identified R10 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was independent with eating.	20960	Corrected.	05/19/2026

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20960	Continued from page 31 During an observation on 4/7/26 at 8:18 a.m., R10 was observed in the dining hall tasting his food (French toast, eggs), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R15's quarterly Minimum Data Set (MDS) dated 2/12/26, identified R15 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required setup/clean up assistance with eating. During an interview on 4/7/26 at 8:40 a.m., R15 stated the food is cold sometimes, and doesn't know why they have such a hard time keeping the food warm, especially when residents are in the dining hall. She has stopped telling staff about the cold food, they don't do anything to change how they keep things hot. R30's quarterly Minimum Data Set (MDS) dated 3/36/26, identified R30 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required setup/clean up assistance with eating. During an interview and tray tasting on 4/7/26 at 12:37 p.m., dietary manager (DM)-A stated the plate covers in the dining hall, seen this morning, were just started today as a response to complaints of cold food. DM manager tasted food and noted the temperature of the food "seemed appropriate" to her. She does not attend resident council; she "might at some point" but right now she hasn't gone to any of the meetings. It is important to know how residents feel about the food so she can adjust based on their concerns. During an interview on 4/7/26 at 1:15 p.m., ombudsman (OM)-A stated residents at the facility started reaching out to her in October 2025 about the ongoing concerns with food temperatures and food being served cold. She also informed management about food menu options as well. During an interview on 4/13/26 at 10:04 a.m., DM-A stated residents frequently ask for foods to be reheated during meal services. Again, stated the lids on meal plates were started as a response to	20960		05/19/2026

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20960	Continued from page 32 complaints about food temperatures; was unsure if they are helping with temperature or not. During an interview on 4/14/26 at 9:27 a.m., administrator stated she would expect residents to tell any facility staff about cold food. She stated she had not heard any concerns about cold food recently. Additionally, the plate lids weren't necessarily new, they just resumed the practice as an infection prevention method. Due to recent dietary staff changes and recommendations from the regional dietary staff, they had ceased this practice; but now had opted to bring it back. It is important to keep foods warm, so residents enjoy their food. A facility policy titled Food Temperatures dated 8/16/22, food must be cooked to appropriate temperatures, held appropriate temperatures. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure proper temperature for meals served. The facility could update or create policies and procedures, and educate staff on proper temperature for meals served to residents. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure proper temperatures of meals served to residents. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 days	20960		05/19/2026
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 2 of 2 residents (R5, R20) reviewed for transmission-based precautions.	21375	Corrected.	05/19/2026

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21375	Continued from page 33 Findings include: R20’s quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition with no hallucination, delusions or other behavioral symptoms noted and was dependent on staff for activities of daily living (ADLs) except eating which R20 required maximal staff assistance. The MDS indicated R20 had an indwelling catheter. During an observation on 4/8/26 at approximately 7:20 a.m., RN-A was observed to enter R20’s room and performed hand hygiene prior to entering room with hand sanitizer. A plastic bin was observed outside the doorway and inside the bin were personal protective gowns and gloves. Hand sanitizer was available from a dispenser on the wall. On the door, was a single page sign hung indicating "Enhanced Barrier Precautions." Signage was orange in color, CDC (Center for Disease Control and Prevention) emblem on the bottom right corner, two stop signs on the upper right and upper left corners of the page and indicated: " Everyone must: Clean their hands, including before entering and when leaving the room," and "Providers and Staff must also: 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, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wounds Care: any skin opening requiring a dressing." R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A. RN-A performed a respiratory assessment on R20 which included a pulse oximeter reading, and breath sounds. RN-A held R20’s inhaler while she did the treatment, then had R20 rinse her mouth and spit in a cup that RN-A was holding. RN-A prepared R20’s nebulizer and placed the mask on R20’s face. RN-A placed R20’s call light pad on her lap and instructed her to turn her call light on when the treatment was completed. RN-A exited R20’s room and used hand sanitizer. R20’s April medication/treatment administration report (MAR), printed 4/14/26, included the following	21375		05/19/2026

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21375	Continued from page 34 order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR. -Respiratory assessment prior to nebulizer treatment. Document Respirations, Pulse, O2 Sat, and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being documented with code. -Respiratory assessment after nebulizer treatment. Document Respirations, Pulse, O2 Sat, and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being documented with code. -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26. -Catheter care every morning and at bedtime for urinary retention with a start date of 1/20/26. R20's order summary report, dated 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. -Catheter Care every morning and at bedtime for urinary retention starting 1/20/26.	21375		05/19/2026

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21375	Continued from page 35 -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26. R20's care plan, initiated on 1/20/26, indicated R20 had indwelling urinary catheter. Interventions were all updated on 3/8/26 and included: administer medications per MD order; catheter care; catheter collection bag place din dignity bag holder on b ed/wheelchair; change urinary collection bag as needed; maintain drainage bag below bladder level; report any changes in amount and color, or odor of urine; report to MD signs of UTI (urinary tract infection) such as blood, cloudy urine, fever, increased restlessness, lethargy, complaints of pain or burning. The care plan lacked identification R20 was on enhanced barrier precautions. During an interview on 4/8/26 at 11:50 a.m., RN-A verified they did administer R20's medications 4/8/26 which included a nebulizer, inhaler, oral medications and performed a respiratory assessment. RN-A stated they did not wear a gown and stated they did not touch R20's catheter which was the reason R20 was on EBP. RN-A stated they should have worn a gown since they did a respiratory assessment with the resident and the EBP sign on the door. R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical	21375		05/19/2026

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21375	Continued from page 36 device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she should have been wearing the appropriate personal protective equipment (PPE) when providing care or administering medications to R5. She stated R5 required enhanced barrier precautions (EBP) and additional PPE (gown and gloves) were needed due to her g-tube. She stated the appropriate PPE is important to prevent the spread of infection from residents to residents. During an interview on 4/14/26 at 9:55 a.m., director of nursing (DON) stated the expectation would be that if a resident on enhanced barrier precautions, the proper PPE would be worn as this helps stop the transmission of infections. DON stated she would expect proper PPE to be worn for a resident on EBP while a respiratory assessment is being performed along with a setting up and administering a nebulizer treatment. A facility policy titled Enhanced Barrier Precautions, dated 8/8/24, identified the facility will implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms and an order for enhanced barrier precautions will be initiated for residents with any of the following: “Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, peripherally inserted central catheters (PICCs), hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MORO. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions.” SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE use. They could also do environmental rounds and audits, and re-education anytime EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement	21375		05/19/2026

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21375	Continued from page 37 (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		05/19/2026
21530	Drug Regimen Review CFR(s): MN Rule 4658.1310 A.B.C A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility	21530	Corrected.	05/19/2026

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21530	Continued from page 38 failed to identify irregularities in monthly drug regimen monitoring review for 1 of 5 residents (R15) reviewed for unnecessary medications who received antipsychotic medications. Additionally, the facility failed to identify potential medication side effects for 1 of 1 resident (R5) reviewed for medication administration. Findings include: R15's quarterly Minimum Data Set (MDS), dated 2/12/26, identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing) During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April. During a record review of R15's pharmacy review and recommendations, the pharmacist failed to address the lack of blood pressure monitoring being completed by staff in the course of their monthly reviews on 11/4/25, 2/5/26, and 4/7/26 for the above-mentioned months. During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her orthostatic blood pressure completed monthly.	21530		05/19/2026

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21530	Continued from page 39 Additionally, if orthostatic blood pressures were ordered, it was her expectation they should get completed monthly. When the consultant pharmacist performed the monthly review of medications, they were to identify when orthostatic blood pressures weren't being completed and should put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible. During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. Additionally, she would expect nursing to complete the orders as written and document why they weren't done. Lastly, since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures. R5 According to the American Society for Parenteral and Enteral Nutrition article, "Medication via Enteral Feeding Tubes: A Clinician's Guide", located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities.	21530		05/19/2026

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21530	Continued from page 40 R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5's care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. R5's phyician's order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician's orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily	21530		05/19/2026

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21530	Continued from page 41 -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. Additionally, she relies on the consultant pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. Additionally, medication interactions should be managed by the facility provider and pharmacist. Further, medication administration times should be assessed by the facility provider and pharmacist. Medications given with other medications or around tube feedings can have side effects for R5 that include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. The medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission.	21530		05/19/2026

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21530	Continued from page 42 During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist could develop and/or revise policies to monitor medications for adequate monitoring to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. Audits could be	21530		05/19/2026

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21530	Continued from page 43 developed to monitor medications for adequate monitoring. The DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further education. TIME PERIOD FOR CORRECTION: 21 DAYS	21530		05/19/2026
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 1 resident (R15) reviewed for unnecessary medication use and who consumed antipsychotic medication. Findings include:	21535	Corrected.	05/19/2026

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21535	Continued from page 44 Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing). R15's quarterly Minimum Data Set (MDS), dated 2/12/26, identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review, R15's orders reflected orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April During a record review of R15's pharmacy review and recommendations indicated the following. In: -4/7/26: did not address orthostatic blood pressures not done in March 2026 or April 2026 -2/5/26: did not address orthostatic blood pressure not done in January 2026 -11/4/26: did not address orthostatic blood pressure not done in October 2026 During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her	21535		05/19/2026

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21535	Continued from page 45 orthostatic blood pressure completed monthly. Additionally, if orthostatic blood pressures are ordered, it is her expectation they get completed monthly. When the consultant pharmacist performs the monthly review of medications, she would identify when orthostatic blood pressures aren't being completed and would put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible. During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. She would expect nursing to complete the orders as written and document why they weren't done. Since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental,	21535		05/19/2026

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21535	Continued from page 46 physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		05/19/2026
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be	21545	Corrected.	05/19/2026

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21545	Continued from page 47 filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%) resulting in an 8.57 % medication error rate, identified during 3 of 25 medication administration observations. Findings include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5’s physician’s orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily	21545		05/19/2026

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21545	Continued from page 48 -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily (prepped 15ml) -ascorbic acid (vitamin C) 500 mg via g-tube daily During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 15 ml instead of the ordered 10 ml. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she had not had g-tube education for "some time." RN-A stated the facility had not had a resident that required tube feedings with medication administration or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. RN-A stated she should have read the pharmacy alerts on the medications. She acknowledged she should have verified the liquid dose a 2nd time to make sure she had the right amount of the liquid. During an interview on 4/9/26 at 11:22 a.m., assistant director of nursing (ADON) stated the process to administer medication includes verifying the right resident, right dose, right route, right drug, and right time. She stated if the individual medications have a pharmacy alert such as take with food, don't give with certain medications; it is an expectation you follow those drug administration	21545		05/19/2026

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21545	Continued from page 49 guidelines. She stated if you don’t follow those recommendations, medications could be less effective, more effective, cause side effects, or not be effective at all. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated she doesn’t check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. During an interview on 4/14/26 at 9:35 a.m., the administrator stated the medication regulation is facilities should have less than a 5% error rate. The facility’s medication error rate of 8.57% is above the acceptable regulation standard. Staff should be confirming the five medication rights (right resident, right dose, right route, right drug, and right time) and it is an expectation staff should follow the pharmacy directions on each medication package. If staff can’t follow the direction of medication from pharmacy, they are expected to reach out to pharmacy or the resident’s provider to get order administration clarification. She stated the importance of performing medication administration accurately is to maintain patient safety. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of time to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits could be taken to the quality assurance performance improvement (QAPI) committee to determine compliance or the need for continued monitoring.	21545		05/19/2026

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21545	Continued from page 50 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		05/19/2026
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and care plan to ensure competency and safety with self-administration of medication for 1 of 1 resident (R20) observed to be self-administering medication in their room. Findings include: R20's quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition. On 4/8/26 at approximately 7:20 a.m., R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A along with an inhaler after performing a respiratory assessment. RN-A prepared R20's nebulizer and placed the mask on R20's face. RN-A placed R20's call light pad on her lap and instructed her to turn her call light on when the treatment was completed. R20 stated she always puts the light on when she was finished with the treatment. On 4/8/26 at 7:52 a.m., assistant director of nursing (ADON) told RN-A that she had removed R20 nebulizer mask and performed the post - respiratory assessment. R20's April medication/treatment administration report (MAR), printed 4/14/26, included the following order:	21565	Corrected.	05/19/2026

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21565	Continued from page 51 -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR. The MAR lacked evidence that R20 was able to administer the medication independently after staff set up. R20's order summary report, dated 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The order summary report lacked an order or evidence that R20 was able to administer the medication independently after staff set up. R20's care plan, with an initiation date of 4/8/26 (after survey entrance) for self-administration of medications/treatments indicated "nurse to set up Neb and place mask on resident for resident to complete without supervision. Nurse to return to take mask off and complete prost respiratory assessment when treatment is complete." The care plan lacked evidence of identification of R20 being assessed and able to self-administer nebulizer prior to 4/8/26. R20's entire medical record was reviewed and lacked any assessment, physician order, or care planning which demonstrated R20 had been evaluated for their ability to self-administer medication. During an interview on 4/8/26 at 11:50 a.m., RN-A stated if a resident was cognitively aware, then the resident could be left alone with a nebulizer after set up. RN-A stated we know our residents and who can be left alone with nebulizer treatments. RN-A verified that R20 was left alone in her room with her nebulizer treatment this morning and this was the facility practice. RN-A stated R20 was able to push	21565		05/19/2026

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21565	Continued from page 52 her call light when the treatment was completed to have the mask removed. RN-A stated a self-administration assessment should be completed for residents who self-administer medications. RN-A verified an assessment had not been completed for R20. During an interview on 4/8/26 at 11:56 a.m., ADON verified she had turned off R20's nebulizer treatment earlier today and removed her nebulizer mask. ADON verified R20 had been in her room alone. ADON stated if a resident was left in their room while completing a nebulizer treatment, it would be expected a self-administration of medication assessment would be completed as this would be self-administration of medication. ADON verified this had not been completed for R20. ADON stated she was going to complete an assessment. During an interview on 4/14/26 at 9:58 a.m., director of nursing (DON) stated the expectation would be if a resident was left with a nebulizer, a self-administration of medication assessment would be completed as it's important because the residents have to have the knowledge and understanding of what the medications is used for and why. DON stated they must be properly assessed. A facility policy titled Medication Administration Self-Administration by resident, reviewed 1/26, identified "residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Facilities must adhere to state specific laws and regulations." Furthermore, the document identified an assessment will be conducted to assess the resident's cognitive, physical and visual ability to carry out the responsibility. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental	21565		05/19/2026

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21565	Continued from page 53 ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		05/19/2026
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident;	21830	Corrected.	05/19/2026

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21830	Continued from page 54 (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to notify 1 of 1 resident's (R5) representative (also the Power of Attorney) when R5 was sent to the emergency department after a fall, and for repeated refusals of care upon her return to the facility.	21830		05/19/2026

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21830	Continued from page 55 Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. During a record review, R5's dismissal summary from the 2/12/26 hospitalization; the hospital physician stated, "R5 is unable to receive and evaluate information effectively and communicate decisions necessary to manager her health. I recommend that the provisions contained in her Power of Attorney for Health Care be activated". During a record review, R5's POA was activated at the facility upon return from the 2/12/26 hospitalization. R5's care plan failed to address R5's refusals of care; additionally, the care plan failed to provide direction, so staff knew when to notify provider and POA about refusals of care and medications. R5's orders failed to address R5's refusals of care; additionally, the orders lacked direction, so staff knew when to notify the medical providers and POA about refusals of care and medications. During record review, R5 refused medications or treatment on the following dates after the POA was activated: -3/6/26: refusal to have blood drawn, no POA notification -4/6/26: refused weight measurements, no POA notification -4/7/26 at 5:16 a.m.: refused constipation medication, no POA notification	21830		05/19/2026

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21830	Continued from page 56 -4/7/26 at 12:22 p.m.: refused constipation medication, no POA notification -4/7/26 at 8:58 p.m.: R5 stated her pain was worse, no POA notification -4/8/26 at 4:58 a.m.: R5 stated her pain had gotten worse, refused all bowel medications, no POA notifications. During record review, there was no documentation R5's POA had been notified prior to leaving the facility to go to the Emergency Room (ER) on 2/12/26 after suffering a fall at the facility. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's POA was activated when she returned from the hospital on 2/22/26. DON stated the POA was activated when R5 was in the hospital because R5 had increasing periods of confusion and lack of understanding about her medical status. DON confirmed R5 has been intermittently refusing cares or treatments since the beginning of February. DON stated the facility doesn't notify the POA of refusals but probably should if the resident doesn't understand her condition or how the meds work. The DON stated it is important to notify the POA about refusal of cares and treatments, so the POA knows the treatments R5 is or isn't receiving. Attempted phone call to speak with R5 POA made on 4/7/26 at 10:45 a.m. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated she was aware R5 had intermittently been refusing medications. PA-A stated she would expect to be notified of ongoing refusals. PA-A stated R5 did not have an order to notify facility providers or POA of refusals of cares or treatments. PA-A stated notification to the POA is important, so the POA understands what treatments R5 isn't getting and why. Additionally, the POA may have some influence with R5 and encourage R5 to accept the cares and treatments. A facility policy titled Change in Condition of the Resident dated 9/20/2022, identified the facility should immediately inform the resident's representative when there is a need to alter	21830		05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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21830	Continued from page 57 treatment or a need to discontinue an existing treatment due to adverse consequences, or to commence a new form of treatment. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee should develop and implement measures to ensure timely notification to the physician. The facility should update policies and procedures, educate staff on those changes, and perform measurable audits to ensure the needs of resident(s) are maintained. The facility should report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		05/19/2026
21925	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 29 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the Office of the State Long-Term Cate (LTC) Ombudsman for 2 of 2 residents (R5 and	21925	Corrected.	05/19/2026

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21925	Continued from page 58 R39) reviewed for hospitalizations and discharges. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's face sheet indicated R5 was originally admitted to the facility on 1/16/26. R5 was hospitalized on 2/12/26 and 3/6/26. R5's Progress notes lacked any communication with the ombudsman after each hospitalization. Review of the notices to the Ombudsman, provided by the facility, identified the notice sent on 3/8/26 did not include R5's hospitalizations. During an interview on 4/7/26 at 12:52 p.m., ombudsman (OM)-A stated she had received a notification from the facility on 3/8/26; this notification contained information about hospitalizations, transfers, and discharges from November and December. OM-A stated she has not received any other notifications for the months of January, February, and March. During an interview on 4/10/26 at 10:22 a.m., social services (SS)-A stated he is responsible for sending notification to the ombudsman about hospitalizations, transfers, and discharges; these notifications are supposed to be sent monthly. SS-A confirmed he is "behind a little with submitting" the notifications to the ombudsman. SS-A stated ombudsman notification are important, so residents have advocate if they feel they have been wrongly hospitalized, transferred, or discharged. R39's admission Minimum Data Set (MDS)	21925		05/19/2026

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21925	Continued from page 59 assessment, dated 2/17/26, identified R39 had moderately impaired cognition and required moderate to maximum staff assistance with activities of daily living (ADLs). R39's diagnoses included: displaced fracture of the base of the left femur, hip fracture, coronary artery disease (heart disease), heart failure (heart not functioning properly), hypertension (high blood pressure), and diabetes mellitus (condition where the body's ability to manage glucose is impaired). R39's progress dated 2/11/26 to 3/6/26 identified a progress note dated 2/11/26 at 10:53 a.m., indicated R39 was admitted to the facility. Another progress noted dated 3/6/26 at 5:43 p.m., indicated R39 discharged home to a new apartment from the facility. The progress notes lacked any communication with ombudsman during planning process of R39's discharge. Review of the notices to the Ombudsman, provided by the facility, identified a notice sent on 3/8/26 did not include R39. During an interview on 4/13/26 at 9:56 a.m., social services (SS)-A stated that he had worked with R39 for her planned discharge. SS-A stated R39 had a case manager who also assisted with the discharge. SS-A stated he had not coordinated with the ombudsman or updated the ombudsman that R39 was planning to discharge prior to discharge. SS-A was unsure if he updated the ombudsman after R39 discharged. If R39 was not on the list provided to surveyors that was sent to the ombudsman's office the beginning of March, then the ombudsman had not been notified. A facility policy titled Transfer and Discharge (including AMA), reviewed 7/15/22, identified for non-emergency transfer or discharges which were initiated by the facility and return not anticipated, a copy of notice shall be provided to a representative of the Office of the State Long-Term Care Ombudsman. Furthermore, instances of emergency transfers/discharges, the social services director or designee, shall provide notice of transfer to a representative of the State Long-term Care Ombudsman via monthly list. SUGGESTED METHOD OF CORRECTION: The Director of Social Work or designee could review	21925		05/19/2026

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21925	Continued from page 60 facility policies and procedures for transfer and discharge notification, and develop a system to ensure the ombudsman is given notice when the facility initiates a resident transfer. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		05/19/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/6/26 through 4/14/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed:	20000		05/19/2026

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

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20000	Continued from page 1 H53195940C (255111746 and 2739638) and H53191098C (247735426). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		05/19/2026
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member	20265	Corrected.	05/19/2026

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20265	Continued from page 2 of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to notify 1 of 1 resident's (R5) representative (also the Power of Attorney) when R5 was sent to the emergency department after a fall, and for repeated refusals of care upon her return to the facility. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional	20265		05/19/2026

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20265	Continued from page 3 urinary incontinence but was always continent of bowel. During a record review, R5's dismissal summary from the 2/12/26 hospitalization; the hospital physician stated, "R5 is unable to receive and evaluate information effectively and communicate decisions necessary to manager her health. I recommend that the provisions contained in her Power of Attorney for Health Care be activated". During a record review, R5's POA was activated at the facility upon return from the 2/12/26 hospitalization. R5's care plan failed to address R5's refusals of care; additionally, the care plan failed to provide direction, so staff know when to notify provider and POA about refusals of care and medications. R5's orders failed to address R5's refusals of care; additionally, the orders lacked direction, so staff knew when to notify the medical providers and POA about refusals of care and medications. During record review, R5 refused medications or treatment on the following dates after the POA was activated: -3/6/26: refusal to have blood drawn, no POA notification -4/6/26: refused weight measurements, no POA notification -4/7/26 at 5:16 a.m.: refused constipation medication, no POA notification -4/7/26 at 12:22 p.m.: refused constipation medication, no POA notification -4/7/26 at 8:58 p.m.: R5 stated her pain was worse, no POA notification -4/8/26 at 4:58 a.m.: R5 stated her pain had gotten worse, refused all bowel medications, no POA notifications During record review, there was no documentation R5's POA had been notified prior to leaving the	20265		05/19/2026

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20265	Continued from page 4 facility to go to the Emergency Room (ER) on 2/12/26 after suffering a fall at the facility. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's POA was activated when she returned from the hospital on 2/22/26. DON stated the POA was activated when R5 was in the hospital because R5 had increasing periods of confusion and lack of understanding about her medical status. DON confirmed R5 has been intermittently refusing cares or treatments since the beginning of February. DON stated the facility doesn't notify the POA of refusals, probably should if the resident doesn't understand her condition or how the meds work. DON stated it is important to notify the POA about refusal of cares and treatments, so the POA knows the treatments R5 is or isn't receiving. Attempted phone call to speak with R5 POA made on 4/7/26 at 10:45 a.m. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated she was aware R5 had intermittently been refusing medications. PA-A stated she would expect to be notified of ongoing refusals. PA-A stated R5 did not have an order to notify facility providers or POA of refusals of cares or treatments. PA-A stated notification to the POA is important, so the POA understands what treatments R5 isn't getting and why. Additionally, the POA may have some influence with R5 and encourage R5 to accept the cares and treatments. A facility policy titled Change in Condition of the Resident dated 9/20/2022, the facility should immediately inform the resident representative when there is a need to alter treatment or a need to discontinue an existing treatment due to adverse consequences, or to commence a new form of treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures regarding notification of change of condition. The DON or designee could educate all appropriate staff on the policies and procedure on notification of change of condition. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results of monitoring to the	20265		05/19/2026

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20265	Continued from page 5 facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		05/19/2026
20270	Use of Oxygen CFR(s): MN Rule 4658.0090 A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to standards of care to prevent respiratory infections for 1 of 1 residents (R16) who required oxygen for chronic respiratory failure with hypoxia (a condition where the lungs are unable to adequately oxygenate the blood). Findings include: R16's quarterly Minimum Data Set (MDS) assessment, dated 2/11/26, identified R15 had intact cognition with no hallucinations, delusions, or rejection of care with admission date of 11/21/25. R16's admission record indicated on 2/18/26, R16's primary diagnosis was end stage renal disease with secondary diagnoses of chronic respiratory failure with hypoxia, biventricular heart failure (heart not working correctly), dependency on supplemental oxygen, unspecified right bundle-branch block (condition where electrical conduction in the heart is impaired), thoracis aortic ectasia (dilation or bulging in aorta in the chest), and atrial fibrillation (heart not beating correctly). Additional secondary diagnosis, dated 1/21/25, included: pulmonary hypertension (high blood pressure in the arteries of the lungs that strains the heart), and pleural effusion (buildup of excess fluid between the layers of the pleura surrounding the lungs). During an interview on 4/6/26 at 4:08 p.m., R16 was observed to be sitting in his wheelchair receiving oxygen via nasal canula from an oxygen concentrator at 2 liters(l)/minute. R16's oxygen tubing did not have a date or label on it. R16 was observed to have a portable oxygen tank on the	20270	Corrected.	05/19/2026

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20270	Continued from page 6 back of his wheelchair with the oxygen tubing with nasal cannula attached wrapped around it with no date on it. R16 was not sure when the oxygen tubing had been changed. R16's care plan, printed 4/7/26, identified R16 was at risk for respiratory impairment related to chronic respiratory failure with hypoxia with an intervention to administer oxygen per MD orders. The care plan lacked any indication on how often the oxygen tubing should be changed or who would be responsible for changing the oxygen tubing. R16's Order Summary Report, dated 4/6/26, included the following orders: -"2L continuous oxygen via nasal cannula. Concentrator and cylinders with contents and regulators" with a start date of 2/18/26. The Order Summary Report lacked evidence of an order to change oxygen tubing. R16's medication and treatment administration record (MAR/TAR) for 4/1/26 to 4/14/26 included the following orders: -change oxygen tubing and humidifier bottles weekly. Date tubing in the afternoon every Thursday with a start date of 4/16/26. - Change oxygen tubing and humidifier bottles weekly. Date tubing as needed for visibly soiled or known contamination with a start date of 4/9/26. This order had a start date after survey entrance. -Oxygen at 2L/minute via nasal cannula every shift with a start date of 4/9/26 R16's Medication Administration Record and Treatment Administration Record (MAR/TAR) for March 2026 was reviewed and lacked any order for oxygen use or changing of oxygen tubing or oxygen supplies. R16's task log was reviewed and did not include any change of oxygen tubing. R16's progress notes from 3/1/26 through 4/7/26, made no mention of any oxygen tubing having been changed by staff.	20270		05/19/2026

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20270	Continued from page 7 Observation and interview ON 4/7/26 at 8:29 a.m., of R16 identified he was observed sitting in his room in his wheelchair and reported he just got done eating. R16's oxygen tubing from the oxygen tank on the back of the chair was observed to be partially on the floor with no date on it. R16's oxygen tubing from the concentrator, which R16 was observed wearing, did not have a date on it. R16 stated the facility will change the tubing when it "doesn't fit" but couldn't explain what that meant or when the last time the tubing was changed. At 12:17 p.m., R16 was observed in the dining room for lunch. R16 was observed to have oxygen on via nasal cannula from his portable tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/8/26 at 9:55 a.m., R16 was observed to be leaving the facility. R16 was observed to have nasal cannula on and receiving oxygen from portable oxygen tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/9/26 at 2:53 p.m., R16 was observed propelling self in wheelchair in his room. R16 was observed receiving oxygen via nasal cannula from the portable tank located on the back of his wheelchair. The oxygen tubing, including the nasal cannula, from the oxygen concentrator was noted to be laying in a box on the floor. Neither oxygen tubing was dated or labeled. R16 stated he was unsure when the oxygen tubing was last changed. During an interview on 4/9/26 at 2:54 p.m., NA-C stated they are familiar with R16. Staff put oxygen on and off residents including R16. NA-C stated nursing assistants do not change oxygen tubing. NA-C observed R16's oxygen tubing and verified the set of oxygen tubing (from the oxygen tank or oxygen concentrator) was dated or labeled. NA-C stated they are unsure when it was last changed as it was not dated. During an interview on 4/10/26 at 12:54 p.m., nursing assistant (NA)-A stated they do not change the oxygen tubing for residents. Staff only turn the oxygen on and off and do not adjust any settings. NA-A thought it was the nurse's responsibility to change the tubing as nurse aides have never changed oxygen tubing.	20270		05/19/2026

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20270	Continued from page 8 During an interview on 4/10/26 at 1:03 p.m., registered nurse (RN)-A stated oxygen tubing and supplies should be changed weekly to prevent infections and the nurses are responsible for this. During an interview and document review on 4/10/26 at 1:04 p.m., RN-C stated oxygen tubing should be changed weekly, and nurses were responsible for ensuring that was completed. RN-C stated there would be an order to change the oxygen tubing. RN-C stated it was expected to date and label the oxygen tubing also. RN-C reviewed R16's medical record and verified the order to change R16's oxygen tubing was entered on 4/9/16 (after survey entrance) and there was no previous order. RN-C stated it was important to change oxygen tubing to prevent infection and prevent build up in the nasal cannula. During an interview on 4/10/26 at 3:21 p.m., the assistant director of nursing (ADON) stated the expectation was oxygen tubing was changed weekly for infection control purposes as not changing it can contribute to respiratory illnesses. The expectation would be for tubing and all supplies to be dated and labeled. The ADON verified there were no additional nursing or physician's orders prior to 4/9/26, to change R16's oxygen tubing or humidifier bottles and there should have been. On 4/14/26 at 9:53 a.m., the director of nursing (DON) stated the expectation would be oxygen tubing would be changed weekly and as needed to help decrease risk of infection as not changing it can put a resident more at risk for infection. This was to be documented on the MAR/TAR. Review of the current, undated Northwest Respiratory Services instruction sheet for oxygen use the facility used for direction for staff, identified staff were to change tubing every month and the nasal cannula every week. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents' oxygen tubing is changed and dated routinely. The DON or designee could educate all appropriate staff on the policies and procedures	20270		05/19/2026

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20270	Continued from page 9 and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20270		05/19/2026
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement a person-centered care plan for 1 of 1 resident (R5) reviewed for comprehensive care plans. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's hospital discharge summary dated 2/25/26 noted the following: -Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air	20555	Corrected.	05/19/2026

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20555	Continued from page 10 -Skin problem to left heel: clean, dry, intact: treatment offloading and open to air -Skin problem to right heel: clean, dry, intact: treatment open to air R5's current, undated care plan indicated the following: urinary incontinence: report changes in skin integrity found during daily care potential for pressure ulcer development: administer treatments as ordered, and monitor effectiveness follow facility policies/protocols for the prevention/treatment of skin breakdown monitor nutritional status monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth) The need for a feeding tube/potential complications from that tube. R5 was to have no complications from the feeding tube. Staff were to administer formula and hydration and flushes per order. R5's care plan lacked identification of skin breakdown on R5's coccyx; further lacking goals and interventions for monitoring, treating, and documenting R5's actual skin breakdown. Additionally, R5's care plan lacked identification of R5's refusal of cares and treatments; further lacking goals and interventions to apply when R5 refused cares and treatments. R5's care plan lacked identification of R5's risk for fluid-volume imbalances; further lacking goals and interventions for monitoring, treating and documentation. R5's care plan lacked specific time requirements to elevate the head of the bed (HOB) to 30-45 degrees during and after tube feeding. Lastly, R5's care plan lacked specific symptoms and side effects of hypercalcemia, hypothyroidism, and hyperparathyroidism. R5's February, March, and April 2026 treatment administration record (TAR) noted to "Monitor	20555		05/19/2026

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20555	Continued from page 11 Mepilex dressing to buttock daily and change every 3 days and as needed when soiled" beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 is a complicated resident due to her multiple medical problems including hypercalcemia, hypothyroidism, hyperparathyroidism, nausea, vomiting, and gastrectomy tube (g-tube) a device surgically inserted through the belly directly into the stomach to deliver nutrition, fluids, and medications). PA-A stated she would expect to see a care plan for each of these areas. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5 had a Stage I pressure ulcer; her care plan did not reflect any goals or interventions to care for and prevent worsening of the pressure ulcer. DON confirmed R5's care plan only indicated a risk for pressure ulcers; should have identified the actual Stage I pressure ulcer and contain interventions such as encouraging position changes, how often to monitor the coccyx, and treatment directions. The DON stated R5's care plan did not include information about her refusal of cares and treatments. The DON stated this care plan would identify the interventions that could have worked to encourage R5 to follow care and treatment orders. The DON stated R5 did not have a fluid-volume care plan. This care plan would be beneficial so staff could monitor and document fluids; this would be important for the resident since she had a G-tube. The DON stated this resident is complicated, R5's care plan should probably have more detail about her medical conditions so staff could be aware of the symptoms or side effects. The DON stated a complete and comprehensive care plan is important so facility staff could identify, monitor, and treat R5's medical issues. During an interview on 4/8/26 at 2:39 p.m., PA-A stated she would expect a complete and comprehensive care plan; a comprehensive care plan allows the facility to adjust cares and interventions based on R5's needs and desire for treatment. PA-A stated she would specifically expect to see a care plan for skin breakdown, fluid intake-output, refusals of care, and tube feeding	20555		05/19/2026

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20555	Continued from page 12 care. PA-A stated care plans are important because they can be tied into the treatment and medication tasks the facility staff perform; without a specific care plan, staff might not know how to provide specific types of care. A facility policy titled Comprehensive Care Plan dated 9/23/2022, the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. These objectives will be used to monitor the residents' progress. Alternative interventions will be documented, as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		05/19/2026
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to prevent complications	20875	Corrected.	05/19/2026

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20875	Continued from page 13 of enteral feeding and failed to provide appropriate treatment and services for 1 of 1 resident (R5) reviewed who required tube feedings and medication administration through a gastrostomy tube (g-tube). This failure created the likelihood of serious harm for R5, including worsening symptoms of nausea and vomiting, and additional hospital visits. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5 was admitted to the facility on 1/16/26 with an admission diagnosis of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). A review of R5's medical record identified the following hospitalizations/emergency room visits identified on: 1) 2/12/26: R5 was sent to the hospital after a fall with decrease cognition and returned to the facility on 2/22/26; the primary diagnosis was hypercalcemia. R'5 Power of Attorney (POA) was activated during this hospital visit and thereafter due to ongoing intermittent confusion. Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 2/6/26 at 11:31 p.m.: stated she was sick to her stomach, the record lacked provider notification 2/7/26 at 5:13 p.m.: declined oral medication, she did not wish to take them, the record lacked provider notification	20875		05/19/2026

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20875	Continued from page 14 2/7/26 at 10:54 p.m., stated she was feeling nauseous and “just can’t take them,” referring to her medications, which she refused. The record lacked provider notification 2/9/26 at 3:30 p.m.: R5 took her medications through her g-tube but vomited shortly after administration, record lacked provider notification 2/11/26 at 2:07 p.m.: R5 refused all medications stating, her “stomach can’t handle it.” 2/12/26 at 10:13 a.m., sent to emergency room 2) 3/6/26: R5 was sent to the hospital as a result of increased nausea and vomiting and returned to the facility on 3/10/26; the primary diagnosis was hypercalcemia. Record review of R5’s progress notes indicated the following concerns prior to being sent to emergency room: 3/1/26 at 12:33 p.m.: R5’s g-tube was flushed and R5 reported feeling nauseous after flush 3/2/26 at 10:46 a.m.: R5’s g-tube was flushed and R5 reported feeling nauseous after flush 3/3/26 at 2:28 p.m., in-person visit with physician assistant (PA)-A, discussed R5’s ongoing nausea, no new orders written 3/4/26 at 5:28 p.m., notified by hospital team the calcium level is high from recent blood draw, increase cinacalcet to 90 mg, stop vitamin D, push fluids, and repeat calcium level on 3/6/26 3/6/26 at 12:56 p.m.: R5 vomiting again, instruction to send to emergency room 3/10/26 at 4:55 p.m.: POA remains activated 3) 4/6/26: R5 was sent to the emergency room as a result of increased abdominal pain and returned to the facility on 4/6/26; the primary diagnosis was pleural effusion (collection of fluid around your lungs.) Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 3/17/26 6:06 p.m.: R5 experienced nausea and vomiting, no record of provider or POA notification 3/29/26 at 12:07 p.m.: R5 experienced nausea and vomiting after morning medications, no record of	20875		05/19/2026

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20875	Continued from page 15 provider or POA notification 3/30/26 at 12:13 p.m.: R5 experienced nausea and vomiting after morning medications, no record of provider or POA notification 3/31/26 at 3:40 p.m.: R5 experienced nausea and vomiting after medications, no record of provider or POA notification 4/5/26 at 12:00 p.m.: R5 experienced right-sided abdominal pain that continues until 4/6/26 at 12:00 p.m., ongoing nausea, vomiting, pain; resident sent to emergency room 4) 4/8/26: R5 was sent to the hospital and returned to the facility on 4/9/26; the primary diagnosis was right-sided pneumonia (acute inflammation of the lung caused by an infection, commonly caused by aspiration.). Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 4/6/26 at 6:00 p.m.: returned from emergency room, R5 was noted to "have a heavy stool burden", R5 refused laxatives, no record of provider or POA notification 4/7/26 at 5:16 a.m.: R5 refused laxatives, no record of provider or POA notification 4/7/26 at 12:22 p.m.: R5 refused laxatives, no record of provider or POA notification 4/7/26 at 8:58 p.m.: R5 stated her upper right quadrant pain is worse, no record of provider or POA notification 4/8/26 at 12:15 p.m.: R5 received daily medications and 150 ml water flush while positioned less than 30 degrees 4/8/26 at 12:42 p.m.: R5 experienced nausea and increased right upper quadrant pain 4/8/26 at 2:38 p.m.: R5 experienced nausea and vomiting after receiving 60 ml of the 150 ml water flush, did not proceed with entire amount due to vomiting, R5's care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order	20875		05/19/2026

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20875	Continued from page 16 -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. Additionally, the care plan lacked assessment and interventions for the risk of fluid volume deficits. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily	20875		05/19/2026

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20875	Continued from page 17 During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 has a complicated gastrointestinal (GI) tract. R5 has hyperparathyroidism and this is the source of her hypercalcemia. R5 is no longer a surgical candidate to have her parathyroid removed, symptom management has been the primary direction of care. PA-A stated electrolyte imbalances will be an ongoing concern for R5. PA-A stated she is unsure how often the nutrition team is working with R5 or how involved they are with her care. According to the American Society for Parenteral and Enteral Nutrition article, “Medication via Enteral Feeding Tubes: A Clinician's Guide”, located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities. During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5’s morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 20ml instead of the ordered 15ml.	20875		05/19/2026

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20875	Continued from page 18 Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. At time of administration, RN-A failed to ensure the head of the bed was 30-45 degrees, with the bed remaining at approximately 10 degrees and R5 slouched down in the bed. RN-A stated R5 received a 30ml water flush before medication administration, 30ml water flush in between each medication, and a 150ml water flush at the end of the medication administration. During medication administration, RN-A diluted each medication with approximately 2ml of water, which failed to dilute the medication enough to allow it to pass through the g-tube. When RN-A put the medication into the barrel of syringe attached to the g-tube, the medication was not diluted enough to flow, RN-A then begun adding additional unmeasured amounts of water and continued to add until the medication would flow; 2 medications required pressure from the syringe plunger to flow through the g-tube. During medication administration process, R5 stated she was having increased nausea and abdominal pain. RN-A failed to recognize R5 was still not at the correct position. During administration RN-A failed to flush the g-tube between medications levothyroxine and metoprolol. RN-A was unsure what effect this could have on R5. After administration was completed, RN-A failed to set the head of the bed up to 30-45 degrees; bed remained at approximately 10 degrees with R5 slouched down in bed. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she was unsure how much additional water she had added to dilute medication enough to flow through R5’s g-tube; she guessed it was approximately 5ml. RN-A stated with the complete medication administration and water flushes; R5 had received approximately 450 ml of liquid. RN-A stated she had not had g-tube education for “some time.” RN-A stated the facility had not had a resident that required tube feedings or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had	20875		05/19/2026

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20875	Continued from page 19 been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. When R5 returned to the facility on 3/10/26 her calcium level was 9.5. PA-A stated she expected facility staff to know the basic signs and symptoms of hypercalcemia, including mental status changes, nausea, vomiting, and constipation. PA-A stated she expected the nursing team to follow the standard of practice when administering medication via g-tube, including sitting the head of bed at 30-45 degrees during and after tube feeding and medication administration. Additionally, she was unsure of the amount of water needed to dilute the medication; however, she would anticipate this to be approximately 5-10 ml of water, and the nurse should be keeping track of this to adjust the water flushes during administration. PA-A stated she relies on the pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During observation on 04/08/2026 at 3:09 PM, emergency services arrived at the facility to take R5 to the emergency room; RN-A stated R5 had been experiencing worsening nausea and vomiting and abdominal pain. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. PA-B stated she had included a statement in her discharge summary that stated, “We have asked the staff at your skilled nursing facility (SNF) receive additional education on management of your feeding tube.” PA-B stated she included this statement because R5 had told her she felt the staff at the facility did not know how to use her g-tube. PA-B stated she would expect the facility providers to manage the calcium levels after discharge. PA-B expected the head of the bed to be elevated to 30-45 degrees during and after tube feedings and medication administration. PA-B stated medication interactions should be managed by the facility provider and pharmacist. PA-B stated medication administration times should be assessed by the facility provider and pharmacist. PA-B stated medications given with other medications or around tube feedings can have side effects for R5 that include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. PA-B stated mismanagement of the g-tube with both tube feedings and medication	20875		05/19/2026

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20875	Continued from page 20 administration could result in complications for R5. These complications could include harm, injury, and in worst case, death. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. PH-A stated R5 should be in an upright position during tube feedings and medication administration and up to an hour afterwards. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Additionally, levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. PH-A stated the medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission. During an interview on 4/9/26 at 11:22 a.m., licensed practical nurse (LPN)-B stated R5 had frequent nausea and vomiting. LPN-B stated they only track R5's bowel movements for output. LPN-B stated R5's emesis are not documented in R5's medical record. LPN-B described the process of administering medications via g-tube which did not include elevating head of bed during or after administration of medications or enteral feedings. During an interview on 4/9/26 at 11:42 a.m., registered nurse (RN)-B stated R5 was admitted to her unit at the hospital yesterday evening. Upon arrival at the hospital unit, R5 was nauseous and vomiting. R5 was given medication to resolve these symptoms. RN-B stated she had given R5 her normal medications this morning. RN-B stated the resident has not experienced nausea or vomiting since yesterday. RN-B stated R5 was able to take sips of water or clear liquids without experiencing nausea or vomiting. RN-B stated the resident must be sitting at least 30–45-degree angle during tube feeding and medication administration. RN-B stated if R5 receives tube feeding when not at the correct angle,	20875		05/19/2026

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20875	Continued from page 21 she is at risk for nausea, vomiting, and abdominal pain. Additionally, she would be at a high risk for aspiration or aspiration pneumonia. During an interview on 04/09/2026 at 11:54 AM, PA-C stated frequently monitoring of calcium should be complete weekly until R5's calcium levels are stable, then monthly, then every six months. R5 has been on cinacalcet to manage her high calcium levels; she is on a consistent dose, but ongoing monitoring should still be weekly to bi-weekly. PA-C stated the most common symptoms of hypercalcemia included altered mental status, muscle cramps, and constipation. Nausea and vomiting aren't necessarily a symptom of hypercalcemia; but they are symptoms of the cinacalcet. PA-C stated if R5 was having nausea and vomiting, there is probably another cause for her symptoms. PA-C stated she would expect the facility staff to know the signs and symptoms of hypercalcemia, medication side effects, and how to properly manage the g-tube during tube feedings and medication administration. PA-C stated if R5's g-tube was mismanaged, R5 could be at risk for harm, increasing symptoms of nausea and vomiting and abdominal pain. Additionally, improper positioning during tube feeding and medication administration could result in serious risk for aspiration or other complications. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions; the pharmacy providing the medication will go through the interaction checker; the interaction warnings then get placed on the medication and the medication is delivered to the facility. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing.	20875		05/19/2026

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20875	Continued from page 22 During an interview on 4/7/26 at 3:15 p.m., vice president of success (VPS)-A stated nurses were educated about g-tubes annually and for regular competencies. VPS-A stated nurses can receive g-tube education sporadically; they didn't believe nursing staff were educated about the needs of R5 prior to her arrival. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated she believed the facility provided education to staff about g-tubes but couldn't find the specific education. DON stated she would expect education to be given for g-tubes, tube feeding administration, medication administration, g-tube complications, and g-tube side effects or symptoms. DON stated the facility had not cared for a resident with a g-tube in about a year. DON stated, generally g-tube education is annually, she did not provide g-tube education to staff about this R5 and her specific needs. DON stated it would have been beneficial to have educated staff specifically about R5 so staff could be prepared for any complications. On 4/14/26 at 10:22 a.m., a call was placed to the facility Medical Director; no return call received. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration. A facility policy titled Enhanced Barrier Precautions (EBP) dated 8/8/25, high-contact resident care activities include device care or use: feeding tubes. EBP should be followed when performing high-contact resident care activities. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. A facility policy titled Medical Director Responsibilities dated 4/22/25, the medical director's responsibilities include implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on	20875		05/19/2026

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20875	Continued from page 23 diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care. A Facility Assessment dated 7/11/25, training and skills unique to resident population: our nurses are trained in enteral feedings; our facility not only conducts a skill assessment during floor orientation of nurses and nursing assistants but also conducts monthly competencies of various skills to ensure that annual training occurs to keep skills honed.	20875		05/19/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to monitor and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 1 of 1 resident (R5) reviewed for pressure ulcers. Findings Include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate	20900	Corrected.	05/19/2026

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20900	Continued from page 24 assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). R5's hospital discharge summary dated 2/25/26 noted the following: -Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air -Skin problem to left heel: clean, dry, intact: treatment offloading and open to air -Skin problem to right heel: clean, dry, intact: treatment open to air R5's care plan indicated the following: -urinary incontinence: report changes in skin integrity found during daily care -potential for pressure ulcer development: -administer treatments as ordered, and monitor effectiveness -follow facility policies/protocols for the prevention/treatment of skin breakdown -monitor nutritional status -monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound	20900		05/19/2026

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20900	Continued from page 25 size (length x width x depth) R5's care plan lacked resident-specific interventions to prevent or mitigate pressure ulcers that included reposition changes, specialty pressure redistribution boots for heels, toileting program to prevent wet skin, specialty padding for chairs, and barrier protection creams. R5's February, March, and April 2026 treatment administration record (TAR) noted to "Monitor Mepilex dressing to buttock daily and change every 3 days and as needed when soiled" beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. R5's weekly skin assessments were completed 1/23/26, 1/30/26, 2/7/26, 3/3/26, 3/27/26, and 4/3/26, stating no skin issues. The weekly skin assessments failed to identify R5's coccyx stage I pressure injury, ongoing monitoring, and ongoing assessments. During an interview on 4/7/26 at 11:31 a.m., R5 stated she does have breakdown on her buttocks. R5 stated the staff at the facility put a covering over it every few days; sometimes it gets wet when she is incontinent, so they must replace it then too. R5 is unsure if the skin breakdown is better or worse because she can't see it. Sometimes her buttocks and her heels get sore; but she doesn't get up much so that won't change much. R5 doesn't remember if facility staff have asked her to reposition herself or offered to assist her to reposition. R5 prefers to sit up because she gets nauseous a lot. During an observation and interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated she was not aware R5 had any skin breakdown on her coccyx and awas unaware of fragile skin on her heels. PA-A and the director of nursing (DON) evaluated R5's coccyx, PA-A stated this was a stage I pressure ulcer. Additionally, the mepilex dressing on the coccyx was not placed correctly to prevent further skin breakdown. PA-A stated she would expect to see a pressure ulcer care plan with interventions to prevent further breakdown.	20900		05/19/2026

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20900	Continued from page 26 During an interview on 4/7/26 at 12:02 p.m., DON stated R5 came back from the hospital in February with a stage I pressure ulcer. DON stated the facility ordered the mepilex for her coccyx, but she acknowledged the facility did not update the care plan or TAR to include interventions to prevent or mitigate skin breakdown. DON was unaware about the fragile skin on her heels; acknowledged R5 should have had interventions in place to prevent pressure injuries of her heels. During a follow up interview on 4/7/26 at 3:25 p.m., DON stated R5's care plan was appropriate when she first arrived in January; but should have been updated upon her return in February to include interventions to prevent or mitigate skin breakdown. DON confirmed R5 had a current stage I pressure ulcer. Additionally, the DON confirmed the facility had not been assessing the coccyx weekly since 3/4/26. The DON stated it is important to implement a complete resident-specific care plan to prevent additional skin breakdown and alterations. A facility policy titled Pressure Injuries and Non-Pressure Injuries dated 7/20/22, the facility will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for	20900		05/19/2026

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20900	Continued from page 27 further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		05/19/2026
20930	Rehab - Nasogastric, Gastrostomy tubes CFR(s): MN Rule 4658.0525 Subp. 7 B. Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to monitor daily oral intake and daily output; additionally, the facility failed to develop a system to monitor and assess daily intake and output for 1 of 1 resident (R5) reviewed who required nutritional and hydration support via a gastrostomy tube (g-tube). Findings Include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 required hydration and nutrition via a feeding tube (g-tube). R5’s current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing) requiring the placement of a gastrostomy tube (g-tube) for nutrition and medication administration. R5’s care plan dated 1/26/26 indicated R5 required tube feeding, hydration, and flushes per order, check tube placement prior to meds and feedings, elevating head of bed 30-45 degrees, care of tube per orders, and report signs of aspiration or intolerance of	20930	Corrected.	05/19/2026

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20930	Continued from page 28 feeding. R5's care plan lacked identification for a risk in decreased hydration, lacked the specific signs and symptoms of aspiration, lacked resident-specific interventions to mitigate complications when using the g-tube, and lacked guidance and collaboration for monitoring fluid balance and imbalance. R5's current physician orders included tube feedings (Vital Advanced Formula at 100 milliliters (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150ml of water flush in g-tube after medication administration for the AM medication pass. R5's orders lacked a clear monitoring system for intake and output including urine output, emesis amounts, amount of bowel movement, and amount of oral intake. R5's nutrition assessments dated 1/22/26, 3/2/26, and 3/16/26: section 30 failed to accurately identify how much oral intake the resident received (to adjust free water amounts), section 36 failed to identify gastrointestinal (GI) concerns such as nausea and vomiting, and section 44 failed to identify the amount of emesis the resident experienced (to know when to adjust free water amounts). R5's electronic medical record lacked collaboration, assessments, and outcome about who would be overseeing and managing daily intake and output in relation to the amount of tube feeding and free water flushes R5 should have received to maintain adequate fluid and nutrition. Additionally, the medical record and testing lacked collaboration and follow up to monitor and assess previously known electrolyte imbalances (high calcium, low potassium, high sodium) with a previously low Albumin level of 3.0 (could indicate malnutrition) on 1/6/26. During an interview on 4/7/26 at 11:31 a.m., R5 stated they give her a lot of water during the day and then in the evening they start her tube feedings; she thinks "it is just too much liquid for [her] to handle", and she gets nauseous and vomits at times. R5 stated she wasn't sure who kept track of all that liquid going in, but she felt like it was too much.	20930		05/19/2026

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20930	Continued from page 29 During observation and interview on 4/7/26 at 11:47 p.m., physician assistant (PA)-A had entered R5's room to evaluate her pressure ulcer; upon entering, the resident was vomiting and handed the emesis bag to the nurse. The emesis bag contained approximately 300ml of vomit; a later record review noted this amount was not documented in a treatment administration record (TAR) nor a progress note. Additionally, the TAR and task list did not contain an option to document any output. PA-A stated R5's GI tract was complicated due to her hyperparathyroidism resulting in high calcium levels; symptom management is the primary treatment option as R5 is no longer a surgical candidate. She was "not aware how often nutrition is involved with her care". She was not actively monitoring daily intake and output. She stated she also did not have any laboratory orders for blood draws to assess electrolyte imbalances; "the teams in the hospital might be managing that." During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's tube feeding care plan should have been more resident-specific to include aspects of care such as head-of-bed elevation, medication administration, g-tube complications, and symptoms and side effects. The DON acknowledged they should have been monitoring R5's intake and output more closely, especially the emesis amounts. Fluid balance is important for R5 since she is receiving tube feedings and free water flushes. Staff needed to make sure her hydration and nutrition are adequate. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for the proper care and to ensure the safe administration of enteral nutrition according to professional standards of practice. Nursing staff could be educated as necessary to the importance of safe administration of enteral feeding to avoid complications and/or infections. The DON or designee could audit nursing staff assigned to residents effected and take that information to the quality assurance performance improvement (QAPI) to ensure compliance and determine the need for further	20930		05/19/2026

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20930	Continued from page 30 education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20930		05/19/2026
20960	Dietary Service - Food Quality CFR(s): MN Rule 4658.0600 Subp. 1 Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 4 of 4 residents (R1, R10, R15, and R30) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchen. Findings include: R1’s quarterly Minimum Data Set (MDS) dated 3/12/26, identified R1 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was independent with eating. During an interview on 4/6/26 at 2:56 p.m., R1 stated the food is cold and he must send it back a lot, it doesn’t matter if he eats in the dining hall or his room; the food is always cold. The facility had the hardest time keeping eggs, mashed potatoes, and beans warm. He stated he has told them so many times and, no one ever does anything about it. During an observation on 4/7/26 at 8:13 a.m., R1 was observed in the dining hall tasting his food (French toast), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R10’s comprehensive Minimum Data Set (MDS) dated 2/10/26, identified R10 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was independent with eating.	20960	Corrected.	05/19/2026

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20960	Continued from page 31 During an observation on 4/7/26 at 8:18 a.m., R10 was observed in the dining hall tasting his food (French toast, eggs), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R15's quarterly Minimum Data Set (MDS) dated 2/12/26, identified R15 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required setup/clean up assistance with eating. During an interview on 4/7/26 at 8:40 a.m., R15 stated the food is cold sometimes, and doesn't know why they have such a hard time keeping the food warm, especially when residents are in the dining hall. She has stopped telling staff about the cold food, they don't do anything to change how they keep things hot. R30's quarterly Minimum Data Set (MDS) dated 3/36/26, identified R30 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required setup/clean up assistance with eating. During an interview and tray tasting on 4/7/26 at 12:37 p.m., dietary manager (DM)-A stated the plate covers in the dining hall, seen this morning, were just started today as a response to complaints of cold food. DM manager tasted food and noted the temperature of the food "seemed appropriate" to her. She does not attend resident council; she "might at some point" but right now she hasn't gone to any of the meetings. It is important to know how residents feel about the food so she can adjust based on their concerns. During an interview on 4/7/26 at 1:15 p.m., ombudsman (OM)-A stated residents at the facility started reaching out to her in October 2025 about the ongoing concerns with food temperatures and food being served cold. She also informed management about food menu options as well. During an interview on 4/13/26 at 10:04 a.m., DM-A stated residents frequently ask for foods to be reheated during meal services. Again, stated the lids on meal plates were started as a response to	20960		05/19/2026

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20960	Continued from page 32 complaints about food temperatures; was unsure if they are helping with temperature or not. During an interview on 4/14/26 at 9:27 a.m., administrator stated she would expect residents to tell any facility staff about cold food. She stated she had not heard any concerns about cold food recently. Additionally, the plate lids weren't necessarily new, they just resumed the practice as an infection prevention method. Due to recent dietary staff changes and recommendations from the regional dietary staff, they had ceased this practice; but now had opted to bring it back. It is important to keep foods warm, so residents enjoy their food. A facility policy titled Food Temperatures dated 8/16/22, food must be cooked to appropriate temperatures, held appropriate temperatures. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure proper temperature for meals served. The facility could update or create policies and procedures, and educate staff on proper temperature for meals served to residents. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure proper temperatures of meals served to residents. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 days	20960		05/19/2026
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 2 of 2 residents (R5, R20) reviewed for transmission-based precautions.	21375	Corrected.	05/19/2026

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21375	Continued from page 33 Findings include: R20’s quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition with no hallucination, delusions or other behavioral symptoms noted and was dependent on staff for activities of daily living (ADLs) except eating which R20 required maximal staff assistance. The MDS indicated R20 had an indwelling catheter. During an observation on 4/8/26 at approximately 7:20 a.m., RN-A was observed to enter R20’s room and performed hand hygiene prior to entering room with hand sanitizer. A plastic bin was observed outside the doorway and inside the bin were personal protective gowns and gloves. Hand sanitizer was available from a dispenser on the wall. On the door, was a single page sign hung indicating "Enhanced Barrier Precautions." Signage was orange in color, CDC (Center for Disease Control and Prevention) emblem on the bottom right corner, two stop signs on the upper right and upper left corners of the page and indicated: " Everyone must: Clean their hands, including before entering and when leaving the room," and "Providers and Staff must also: 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, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wounds Care: any skin opening requiring a dressing." R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A. RN-A performed a respiratory assessment on R20 which included a pulse oximeter reading, and breath sounds. RN-A held R20’s inhaler while she did the treatment, then had R20 rinse her mouth and spit in a cup that RN-A was holding. RN-A prepared R20’s nebulizer and placed the mask on R20’s face. RN-A placed R20’s call light pad on her lap and instructed her to turn her call light on when the treatment was completed. RN-A exited R20’s room and used hand sanitizer. R20’s April medication/treatment administration report (MAR), printed 4/14/26, included the following	21375		05/19/2026

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21375	Continued from page 34 order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR. -Respiratory assessment prior to nebulizer treatment. Document Respirations, Pulse, O2 Sat, and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being documented with code. -Respiratory assessment after nebulizer treatment. Document Respirations, Pulse, O2 Sat, and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being documented with code. -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26. -Catheter care every morning and at bedtime for urinary retention with a start date of 1/20/26. R20's order summary report, dated 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. -Catheter Care every morning and at bedtime for urinary retention starting 1/20/26.	21375		05/19/2026

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21375	Continued from page 35 -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26. R20's care plan, initiated on 1/20/26, indicated R20 had indwelling urinary catheter. Interventions were all updated on 3/8/26 and included: administer medications per MD order; catheter care; catheter collection bag place din dignity bag holder on b ed/wheelchair; change urinary collection bag as needed; maintain drainage bag below bladder level; report any changes in amount and color, or odor of urine; report to MD signs of UTI (urinary tract infection) such as blood, cloudy urine, fever, increased restlessness, lethargy, complaints of pain or burning. The care plan lacked identification R20 was on enhanced barrier precautions. During an interview on 4/8/26 at 11:50 a.m., RN-A verified they did administer R20's medications 4/8/26 which included a nebulizer, inhaler, oral medications and performed a respiratory assessment. RN-A stated they did not wear a gown and stated they did not touch R20's catheter which was the reason R20 was on EBP. RN-A stated they should have worn a gown since they did a respiratory assessment with the resident and the EBP sign on the door. R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical	21375		05/19/2026

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21375	Continued from page 36 device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she should have been wearing the appropriate personal protective equipment (PPE) when providing care or administering medications to R5. She stated R5 required enhanced barrier precautions (EBP) and additional PPE (gown and gloves) were needed due to her g-tube. She stated the appropriate PPE is important to prevent the spread of infection from residents to residents. During an interview on 4/14/26 at 9:55 a.m., director of nursing (DON) stated the expectation would be that if a resident on enhanced barrier precautions, the proper PPE would be worn as this helps stop the transmission of infections. DON stated she would expect proper PPE to be worn for a resident on EBP while a respiratory assessment is being performed along with a setting up and administering a nebulizer treatment. A facility policy titled Enhanced Barrier Precautions, dated 8/8/24, identified the facility will implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms and an order for enhanced barrier precautions will be initiated for residents with any of the following: “Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, peripherally inserted central catheters (PICCs), hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MORO. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions.” SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE use. They could also do environmental rounds and audits, and re-education anytime EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement	21375		05/19/2026

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21375	Continued from page 37 (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		05/19/2026
21530	Drug Regimen Review CFR(s): MN Rule 4658.1310 A.B.C A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility	21530	Corrected.	05/19/2026

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21530	Continued from page 38 failed to identify irregularities in monthly drug regimen monitoring review for 1 of 5 residents (R15) reviewed for unnecessary medications who received antipsychotic medications. Additionally, the facility failed to identify potential medication side effects for 1 of 1 resident (R5) reviewed for medication administration. Findings include: R15's quarterly Minimum Data Set (MDS), dated 2/12/26, identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing) During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April. During a record review of R15's pharmacy review and recommendations, the pharmacist failed to address the lack of blood pressure monitoring being completed by staff in the course of their monthly reviews on 11/4/25, 2/5/26, and 4/7/26 for the above-mentioned months. During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her orthostatic blood pressure completed monthly.	21530		05/19/2026

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21530	Continued from page 39 Additionally, if orthostatic blood pressures were ordered, it was her expectation they should get completed monthly. When the consultant pharmacist performed the monthly review of medications, they were to identify when orthostatic blood pressures weren't being completed and should put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible. During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. Additionally, she would expect nursing to complete the orders as written and document why they weren't done. Lastly, since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures. R5 According to the American Society for Parenteral and Enteral Nutrition article, "Medication via Enteral Feeding Tubes: A Clinician's Guide", located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities.	21530		05/19/2026

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21530	Continued from page 40 R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5's care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. R5's phyician's order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician's orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily	21530		05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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21530	Continued from page 41 -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. Additionally, she relies on the consultant pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. Additionally, medication interactions should be managed by the facility provider and pharmacist. Further, medication administration times should be assessed by the facility provider and pharmacist. Medications given with other medications or around tube feedings can have side effects for R5 that include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. The medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission.	21530		05/19/2026

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21530	Continued from page 42 During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist could develop and/or revise policies to monitor medications for adequate monitoring to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. Audits could be	21530		05/19/2026

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21530	Continued from page 43 developed to monitor medications for adequate monitoring. The DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further education. TIME PERIOD FOR CORRECTION: 21 DAYS	21530		05/19/2026
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 1 resident (R15) reviewed for unnecessary medication use and who consumed antipsychotic medication. Findings include:	21535	Corrected.	05/19/2026

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21535	Continued from page 44 Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing). R15's quarterly Minimum Data Set (MDS), dated 2/12/26, identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review, R15's orders reflected orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April During a record review of R15's pharmacy review and recommendations indicated the following. In: -4/7/26: did not address orthostatic blood pressures not done in March 2026 or April 2026 -2/5/26: did not address orthostatic blood pressure not done in January 2026 -11/4/26: did not address orthostatic blood pressure not done in October 2026 During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her	21535		05/19/2026

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21535	Continued from page 45 orthostatic blood pressure completed monthly. Additionally, if orthostatic blood pressures are ordered, it is her expectation they get completed monthly. When the consultant pharmacist performs the monthly review of medications, she would identify when orthostatic blood pressures aren't being completed and would put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible. During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. She would expect nursing to complete the orders as written and document why they weren't done. Since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental,	21535		05/19/2026

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21535	Continued from page 46 physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		05/19/2026
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be	21545	Corrected.	05/19/2026

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21545	Continued from page 47 filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%) resulting in an 8.57 % medication error rate, identified during 3 of 25 medication administration observations. Findings include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5’s physician’s orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily	21545		05/19/2026

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21545	Continued from page 48 -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily (prepped 15ml) -ascorbic acid (vitamin C) 500 mg via g-tube daily During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 15 ml instead of the ordered 10 ml. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she had not had g-tube education for "some time." RN-A stated the facility had not had a resident that required tube feedings with medication administration or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. RN-A stated she should have read the pharmacy alerts on the medications. She acknowledged she should have verified the liquid dose a 2nd time to make sure she had the right amount of the liquid. During an interview on 4/9/26 at 11:22 a.m., assistant director of nursing (ADON) stated the process to administer medication includes verifying the right resident, right dose, right route, right drug, and right time. She stated if the individual medications have a pharmacy alert such as take with food, don't give with certain medications; it is an expectation you follow those drug administration	21545		05/19/2026

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21545	Continued from page 49 guidelines. She stated if you don’t follow those recommendations, medications could be less effective, more effective, cause side effects, or not be effective at all. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated she doesn’t check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. During an interview on 4/14/26 at 9:35 a.m., the administrator stated the medication regulation is facilities should have less than a 5% error rate. The facility’s medication error rate of 8.57% is above the acceptable regulation standard. Staff should be confirming the five medication rights (right resident, right dose, right route, right drug, and right time) and it is an expectation staff should follow the pharmacy directions on each medication package. If staff can’t follow the direction of medication from pharmacy, they are expected to reach out to pharmacy or the resident’s provider to get order administration clarification. She stated the importance of performing medication administration accurately is to maintain patient safety. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of time to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits could be taken to the quality assurance performance improvement (QAPI) committee to determine compliance or the need for continued monitoring.	21545		05/19/2026

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21545	Continued from page 50 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		05/19/2026
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and care plan to ensure competency and safety with self-administration of medication for 1 of 1 resident (R20) observed to be self-administering medication in their room. Findings include: R20's quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition. On 4/8/26 at approximately 7:20 a.m., R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A along with an inhaler after performing a respiratory assessment. RN-A prepared R20's nebulizer and placed the mask on R20's face. RN-A placed R20's call light pad on her lap and instructed her to turn her call light on when the treatment was completed. R20 stated she always puts the light on when she was finished with the treatment. On 4/8/26 at 7:52 a.m., assistant director of nursing (ADON) told RN-A that she had removed R20 nebulizer mask and performed the post - respiratory assessment. R20's April medication/treatment administration report (MAR), printed 4/14/26, included the following order:	21565	Corrected.	05/19/2026

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21565	Continued from page 51 -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR. The MAR lacked evidence that R20 was able to administer the medication independently after staff set up. R20's order summary report, dated 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The order summary report lacked an order or evidence that R20 was able to administer the medication independently after staff set up. R20's care plan, with an initiation date of 4/8/26 (after survey entrance) for self-administration of medications/treatments indicated "nurse to set up Neb and place mask on resident for resident to complete without supervision. Nurse to return to take mask off and complete prost respiratory assessment when treatment is complete." The care plan lacked evidence of identification of R20 being assessed and able to self-administer nebulizer prior to 4/8/26. R20's entire medical record was reviewed and lacked any assessment, physician order, or care planning which demonstrated R20 had been evaluated for their ability to self-administer medication. During an interview on 4/8/26 at 11:50 a.m., RN-A stated if a resident was cognitively aware, then the resident could be left alone with a nebulizer after set up. RN-A stated we know our residents and who can be left alone with nebulizer treatments. RN-A verified that R20 was left alone in her room with her nebulizer treatment this morning and this was the facility practice. RN-A stated R20 was able to push	21565		05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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21565	Continued from page 52 her call light when the treatment was completed to have the mask removed. RN-A stated a self-administration assessment should be completed for residents who self-administer medications. RN-A verified an assessment had not been completed for R20. During an interview on 4/8/26 at 11:56 a.m., ADON verified she had turned off R20's nebulizer treatment earlier today and removed her nebulizer mask. ADON verified R20 had been in her room alone. ADON stated if a resident was left in their room while completing a nebulizer treatment, it would be expected a self-administration of medication assessment would be completed as this would be self-administration of medication. ADON verified this had not been completed for R20. ADON stated she was going to complete an assessment. During an interview on 4/14/26 at 9:58 a.m., director of nursing (DON) stated the expectation would be if a resident was left with a nebulizer, a self-administration of medication assessment would be completed as it's important because the residents have to have the knowledge and understanding of what the medications is used for and why. DON stated they must be properly assessed. A facility policy titled Medication Administration Self-Administration by resident, reviewed 1/26, identified "residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Facilities must adhere to state specific laws and regulations." Furthermore, the document identified an assessment will be conducted to assess the resident's cognitive, physical and visual ability to carry out the responsibility. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental	21565		05/19/2026

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21565	Continued from page 53 ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		05/19/2026
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident;	21830	Corrected.	05/19/2026

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21830	Continued from page 54 (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to notify 1 of 1 resident's (R5) representative (also the Power of Attorney) when R5 was sent to the emergency department after a fall, and for repeated refusals of care upon her return to the facility.	21830		05/19/2026

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21830	Continued from page 55 Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. During a record review, R5's dismissal summary from the 2/12/26 hospitalization; the hospital physician stated, "R5 is unable to receive and evaluate information effectively and communicate decisions necessary to manager her health. I recommend that the provisions contained in her Power of Attorney for Health Care be activated". During a record review, R5's POA was activated at the facility upon return from the 2/12/26 hospitalization. R5's care plan failed to address R5's refusals of care; additionally, the care plan failed to provide direction, so staff knew when to notify provider and POA about refusals of care and medications. R5's orders failed to address R5's refusals of care; additionally, the orders lacked direction, so staff knew when to notify the medical providers and POA about refusals of care and medications. During record review, R5 refused medications or treatment on the following dates after the POA was activated: -3/6/26: refusal to have blood drawn, no POA notification -4/6/26: refused weight measurements, no POA notification -4/7/26 at 5:16 a.m.: refused constipation medication, no POA notification	21830		05/19/2026

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21830	Continued from page 56 -4/7/26 at 12:22 p.m.: refused constipation medication, no POA notification -4/7/26 at 8:58 p.m.: R5 stated her pain was worse, no POA notification -4/8/26 at 4:58 a.m.: R5 stated her pain had gotten worse, refused all bowel medications, no POA notifications. During record review, there was no documentation R5's POA had been notified prior to leaving the facility to go to the Emergency Room (ER) on 2/12/26 after suffering a fall at the facility. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's POA was activated when she returned from the hospital on 2/22/26. DON stated the POA was activated when R5 was in the hospital because R5 had increasing periods of confusion and lack of understanding about her medical status. DON confirmed R5 has been intermittently refusing cares or treatments since the beginning of February. DON stated the facility doesn't notify the POA of refusals but probably should if the resident doesn't understand her condition or how the meds work. The DON stated it is important to notify the POA about refusal of cares and treatments, so the POA knows the treatments R5 is or isn't receiving. Attempted phone call to speak with R5 POA made on 4/7/26 at 10:45 a.m. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated she was aware R5 had intermittently been refusing medications. PA-A stated she would expect to be notified of ongoing refusals. PA-A stated R5 did not have an order to notify facility providers or POA of refusals of cares or treatments. PA-A stated notification to the POA is important, so the POA understands what treatments R5 isn't getting and why. Additionally, the POA may have some influence with R5 and encourage R5 to accept the cares and treatments. A facility policy titled Change in Condition of the Resident dated 9/20/2022, identified the facility should immediately inform the resident's representative when there is a need to alter	21830		05/19/2026

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21830	Continued from page 57 treatment or a need to discontinue an existing treatment due to adverse consequences, or to commence a new form of treatment. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee should develop and implement measures to ensure timely notification to the physician. The facility should update policies and procedures, educate staff on those changes, and perform measurable audits to ensure the needs of resident(s) are maintained. The facility should report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		05/19/2026
21925	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 29 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the Office of the State Long-Term Cate (LTC) Ombudsman for 2 of 2 residents (R5 and	21925	Corrected.	05/19/2026

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21925	Continued from page 58 R39) reviewed for hospitalizations and discharges. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's face sheet indicated R5 was originally admitted to the facility on 1/16/26. R5 was hospitalized on 2/12/26 and 3/6/26. R5's Progress notes lacked any communication with the ombudsman after each hospitalization. Review of the notices to the Ombudsman, provided by the facility, identified the notice sent on 3/8/26 did not include R5's hospitalizations. During an interview on 4/7/26 at 12:52 p.m., ombudsman (OM)-A stated she had received a notification from the facility on 3/8/26; this notification contained information about hospitalizations, transfers, and discharges from November and December. OM-A stated she has not received any other notifications for the months of January, February, and March. During an interview on 4/10/26 at 10:22 a.m., social services (SS)-A stated he is responsible for sending notification to the ombudsman about hospitalizations, transfers, and discharges; these notifications are supposed to be sent monthly. SS-A confirmed he is "behind a little with submitting" the notifications to the ombudsman. SS-A stated ombudsman notification are important, so residents have advocate if they feel they have been wrongly hospitalized, transferred, or discharged. R39's admission Minimum Data Set (MDS)	21925		05/19/2026

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21925	Continued from page 59 assessment, dated 2/17/26, identified R39 had moderately impaired cognition and required moderate to maximum staff assistance with activities of daily living (ADLs). R39's diagnoses included: displaced fracture of the base of the left femur, hip fracture, coronary artery disease (heart disease), heart failure (heart not functioning properly), hypertension (high blood pressure), and diabetes mellitus (condition where the body's ability to manage glucose is impaired). R39's progress dated 2/11/26 to 3/6/26 identified a progress note dated 2/11/26 at 10:53 a.m., indicated R39 was admitted to the facility. Another progress noted dated 3/6/26 at 5:43 p.m., indicated R39 discharged home to a new apartment from the facility. The progress notes lacked any communication with ombudsman during planning process of R39's discharge. Review of the notices to the Ombudsman, provided by the facility, identified a notice sent on 3/8/26 did not include R39. During an interview on 4/13/26 at 9:56 a.m., social services (SS)-A stated that he had worked with R39 for her planned discharge. SS-A stated R39 had a case manager who also assisted with the discharge. SS-A stated he had not coordinated with the ombudsman or updated the ombudsman that R39 was planning to discharge prior to discharge. SS-A was unsure if he updated the ombudsman after R39 discharged. If R39 was not on the list provided to surveyors that was sent to the ombudsman's office the beginning of March, then the ombudsman had not been notified. A facility policy titled Transfer and Discharge (including AMA), reviewed 7/15/22, identified for non-emergency transfer or discharges which were initiated by the facility and return not anticipated, a copy of notice shall be provided to a representative of the Office of the State Long-Term Care Ombudsman. Furthermore, instances of emergency transfers/discharges, the social services director or designee, shall provide notice of transfer to a representative of the State Long-term Care Ombudsman via monthly list. SUGGESTED METHOD OF CORRECTION: The Director of Social Work or designee could review	21925		05/19/2026

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21925	Continued from page 60 facility policies and procedures for transfer and discharge notification, and develop a system to ensure the ombudsman is given notice when the facility initiates a resident transfer. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		05/19/2026

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E0000	Initial Comments On 4/6/26 through 4/14/26, a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E0000		05/19/2026
F0000	INITIAL COMMENTS On 4/6/26 through 4/14/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53195940C (255111746 and 2739638) and H53191098C (247735426). NO deficiencies were cited. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F684 began on 4/8/26, when the facility failed to follow professional standards of medication administration through a g-tube, pharmacy directions for medication administration, identify the symptoms and side effects of incorrectly using the g-tube. Subsequently, R5 experienced nausea and vomiting and was sent to the hospital with a diagnosis of pneumonia.	F0000		05/19/2026

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: 245319	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/14/2026

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F0000	Continued from page 1 The administrator, and director of nursing (DON) were notified of the IJ on 4/9/26 at 6:17 p.m. The IJ was removed on 4/13/26 at 4:07 p.m. The above findings constituted Substandard Quality of Care, and an extended survey was conducted on 4/13/26 and 4/14/26. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/19/2026
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to prevent complications of enteral feeding and failed to provide appropriate treatment and services for 1 of 1 resident (R5) reviewed who required tube feedings and medication administration through a gastrostomy tube (g-tube). This failure created the likelihood of serious harm for R5, including worsening symptoms of nausea and vomiting, and additional hospital visits. The immediate jeopardy (IJ) began on 4/8/26 when the facility failed to follow professional standards of	F0684	R5 was hospitalized 4/8/26 and registered nurse assessment completed upon re-admission on 4/9/26 which included a dehydration risk screener and a head-to-toe assessment. The Registered Dietician completed a Nutrition Assessment, which included estimated fluids needs. Consultant pharmacist or designee was consulted on 04/09/26 and medications were reviewed to ensure prior timing of medications in association with other medication interactions and indications (with food or fasting). Registered Dietician reviewed resident tube feeding and fluid orders on 4/9/26 and verified free fluid orders including water for medication pass. Director of Nursing consulted Primary Care physician on 04/10/26 with consultant pharmacist recommendations regarding timing of medications and Registered Dietician recommendations. Primary Care Physician contacted on 4/10/2026 regarding need for continued labs and at what frequency. Care plan updated 4/10/2026 to reflect observation for signs and symptoms of hyperparathyroidism, hypothyroidism, and at risk for fluid volume deficit and at risk for constipation. Care plan also updated to include both monitoring of intake and output, which would include estimation of amount of emesis, if/when emesis occurs. Current residents that receive medications and/or nutrition via tube feeding have the potential to be affected. No other residents were identified.	05/19/2026

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LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947

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F0684 SS = SQC-J	Continued from page 2 medication administration through a g-tube, pharmacy directions for medication administration, identify the symptoms and side effects of incorrectly using the g-tube. Subsequently, R5 experienced nausea and vomiting and was sent to the hospital with a diagnosis of pneumonia. The administrator and director of nursing (DON) were notified of the IJ on 4/9/26 at 6:17 p.m. The IJ was removed on 4/13/26 at 4:07 p.m., however, noncompliance remained at a lower scope and severity of D, indicating no actual harm with potential for more than minimal harm that was not widespread. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5 was admitted to the facility on 1/16/26 with an admission diagnosis of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). A review of R5's medical record identified the following hospitalizations/emergency room visits identified on: 1) 2/12/26: R5 was sent to the hospital after a fall with decrease cognition and returned to the facility on 2/22/26; the primary diagnosis was hypercalcemia. R'5 Power of Attorney (POA) was activated during this hospital visit and thereafter due to ongoing intermittent confusion. Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 2/6/26 at 11:31 p.m.: stated she was sick to her stomach, the record lacked provider notification	F0684	Continued from page 2 Current residents that receive medications and/or nutrition via tube feeding have ability to be affected by this alleged deficient practice. Facility Policies on Medication administration, Enteral Medication Administration, Hydration, verifying placement of tube feeding, and change of condition policy were reviewed by Interdisciplinary Team on 4/9/2026. Facility Licensed Nurses will be re-educated by Director of Nursing or designee on identified policies and identified medication side effects and signs symptoms of hypothyroidism and hyperparathyroidism starting 4/9/2026 and will be completed prior to start of next scheduled shift. Facility licensed and non-licensed nursing staff were re-educated on positioning importance and elevating head of bed on residents receiving enteral medications and nutrition, starting 04/09/2026, occurring prior to start of next scheduled shift. Nursing assistants re-educated on completion of STOP and WATCH tool and notifying nurse for changes in condition, including subtle changes in condition. Licensed Nurses re-educated on how to respond to alerts, which includes assessment/data gathering and notification of provider when indicated. This eINTERACT/STOP and WATCH education will be completed by the Director of Nursing, or designee, and will be initiated on 4/10/2026 and will be completed prior to next scheduled shift. Staff were notified of need for re-education via a message on the electronic scheduling system. Knowledge check will be completed with Certified Nursing Assistants to validate understanding of STOP and WATCH/change in condition reporting process and a knowledge check will be completed with Licensed nurses regarding tube feeding and change in condition assessment/data gathering. Ad Hoc Quality Assurance and Performance Improvement meeting completed on 04/10/2026 with Interdisciplinary Team and Medical Director to review findings and plan. Audits will be implemented by Director of Nursing or designee starting 04/10/26 on tube feeding administration, medication administration via gastrostomy tube and positioning of resident with enteral nutrition or medications. Audits will be completed daily on varying shifts x 7 days. Audits will continue no less than 3 times per week for 4 weeks or until substantial compliance is maintained. Director of Nursing or Designee will review facility charting daily to identify resident change in condition, to ensure proper documentation of assessment/evaluation and timely provider	05/19/2026

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F0684 SS = SQC-J	Continued from page 3 2/7/26 at 5:13 p.m.: declined oral medication, she did not wish to take them, the record lacked provider notification 2/7/26 at 10:54 p.m., stated she was feeling nauseous and “just can’t take them,” referring to her medications, which she refused. The record lacked provider notification 2/9/26 at 3:30 p.m.: R5 took her medications through her g-tube but vomited shortly after administration, record lacked provider notification 2/11/26 at 2:07 p.m.: R5 refused all medications stating, her “stomach can’t handle it.” 2/12/26 at 10:13 a.m., sent to emergency room 2) 3/6/26: R5 was sent to the hospital as a result of increased nausea and vomiting and returned to the facility on 3/10/26; the primary diagnosis was hypercalcemia. Record review of R5’s progress notes indicated the following concerns prior to being sent to emergency room: 3/1/26 at 12:33 p.m.: R5’s g-tube was flushed and R5 reported feeling nauseous after flush 3/2/26 at 10:46 a.m.: R5’s g-tube was flushed and R5 reported feeling nauseous after flush 3/3/26 at 2:28 p.m., in-person visit with physician assistant (PA)-A, discussed R5’s ongoing nausea, no new orders written 3/4/26 at 5:28 p.m., notified by hospital team the calcium level is high from recent blood draw, increase cinacalcet to 90 mg, stop vitamin D, push fluids, and repeat calcium level on 3/6/26 3/6/26 at 12:56 p.m.: R5 vomiting again, instruction to send to emergency room 3/10/26 at 4:55 p.m.: POA remains activated 3) 4/6/26: R5 was sent to the emergency room as a result of increased abdominal pain and returned to the facility on 4/6/26; the primary diagnosis was pleural effusion (collection of fluid around your lungs.) Record review of R5’s progress notes indicated the following concerns prior to being sent to emergency room: 3/17/26 6:06 p.m.: R5 experienced nausea and	F0684	Continued from page 3 notification. These audits will be completed daily x7 days, then with morning clinical 5 days per week for 8 more weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0684 SS = SQC-J	Continued from page 4 vomiting, no record of provider or POA notification 3/29/26 at 12:07 p.m.: R5 experienced nausea and vomiting after morning medications, no record of provider or POA notification 3/30/26 at 12:13 p.m.: R5 experienced nausea and vomiting after morning medications, no record of provider or POA notification 3/31/26 at 3:40 p.m.: R5 experienced nausea and vomiting after medications, no record of provider or POA notification 4/5/26 at 12:00 p.m.: R5 experienced right-sided abdominal pain that continues until 4/6/26 at 12:00 p.m., ongoing nausea, vomiting, pain; resident sent to emergency room 4) 4/8/26: R5 was sent to the hospital and returned to the facility on 4/9/26; the primary diagnosis was right-sided pneumonia (acute inflammation of the lung caused by an infection, commonly caused by aspiration.). Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 4/6/26 at 6:00 p.m.: returned from emergency room, R5 was noted to "have a heavy stool burden", R5 refused laxatives, no record of provider or POA notification 4/7/26 at 5:16 a.m.: R5 refused laxatives, no record of provider or POA notification 4/7/26 at 12:22 p.m.: R5 refused laxatives, no record of provider or POA notification 4/7/26 at 8:58 p.m.: R5 stated her upper right quadrant pain is worse, no record of provider or POA notification 4/8/26 at 12:15 p.m.: R5 received daily medications and 150 ml water flush while positioned less than 30 degrees 4/8/26 at 12:42 p.m.: R5 experienced nausea and increased right upper quadrant pain 4/8/26 at 2:38 p.m.: R5 experienced nausea and vomiting after receiving 60 ml of the 150 ml water flush, did not proceed with entire amount due to vomiting,	F0684		05/19/2026

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F0684 SS = SQC-J	Continued from page 5 R5's care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. Additionally, the care plan lacked assessment and interventions for the risk of fluid volume deficits. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral	F0684		05/19/2026

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F0684 SS = SQC-J	Continued from page 6 suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 has a complicated gastrointestinal (GI) tract. R5 has hyperparathyroidism and this is the source of her hypercalcemia. R5 is no longer a surgical candidate to have her parathyroid removed, symptom management has been the primary direction of care. PA-A stated electrolyte imbalances will be an ongoing concern for R5. PA-A stated she is unsure how often the nutrition team is working with R5 or how involved they are with her care. According to the American Society for Parenteral and Enteral Nutrition article, “Medication via Enteral Feeding Tubes: A Clinician's Guide”, located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities. During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5’s morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.)	F0684		05/19/2026

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F0684 SS = SQC-J	Continued from page 7 RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 20ml instead of the ordered 15ml. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. At time of administration, RN-A failed to ensure the head of the bed was 30-45 degrees, with the bed remaining at approximately 10 degrees and R5 slouched down in the bed. RN-A stated R5 received a 30ml water flush before medication administration, 30ml water flush in between each medication, and a 150ml water flush at the end of the medication administration. During medication administration, RN-A diluted each medication with approximately 2ml of water, which failed to dilute the medication enough to allow it to pass through the g-tube. When RN-A put the medication into the barrel of syringe attached to the g-tube, the medication was not diluted enough to flow, RN-A then begun adding additional unmeasured amounts of water and continued to add until the medication would flow; 2 medications required pressure from the syringe plunger to flow through the g-tube. During medication administration process, R5 stated she was having increased nausea and abdominal pain. RN-A failed to recognize R5 was still not at the correct position. During administration RN-A failed to flush the g-tube between medications levothyroxine and metoprolol. RN-A was unsure what effect this could have on R5. After administration was completed, RN-A failed to set the head of the bed up to 30-45 degrees; bed remained at approximately 10 degrees with R5 slouched down in bed. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she was unsure how much additional water she had added to dilute medication enough to flow through R5's g-tube; she guessed it was approximately 5ml. RN-A stated with the complete medication administration and water flushes; R5 had received approximately 450 ml of liquid. RN-A stated she had not had g-tube education for "some time." RN-A stated the facility had not had a resident that required tube feedings or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January.	F0684		05/19/2026

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F0684 SS = SQC-J	Continued from page 8 During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. When R5 returned to the facility on 3/10/26 her calcium level was 9.5. PA-A stated she expected facility staff to know the basic signs and symptoms of hypercalcemia, including mental status changes, nausea, vomiting, and constipation. PA-A stated she expected the nursing team to follow the standard of practice when administering medication via g-tube, including sitting the head of bed at 30-45 degrees during and after tube feeding and medication administration. Additionally, she was unsure of the amount of water needed to dilute the medication; however, she would anticipate this to be approximately 5-10 ml of water, and the nurse should be keeping track of this to adjust the water flushes during administration. PA-A stated she relies on the pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During observation on 04/08/2026 at 3:09 PM, emergency services arrived at the facility to take R5 to the emergency room; RN-A stated R5 had been experiencing worsening nausea and vomiting and abdominal pain. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. PA-B stated she had included a statement in her discharge summary that stated, “We have asked the staff at your skilled nursing facility (SNF) receive additional education on management of your feeding tube.” PA-B stated she included this statement because R5 had told her she felt the staff at the facility did not know how to use her g-tube. PA-B stated she would expect the facility providers to manage the calcium levels after discharge. PA-B expected the head of the bed to be elevated to 30-45 degrees during and after tube feedings and medication administration. PA-B stated medication interactions should be managed by the facility provider and pharmacist. PA-B stated medication administration times should be assessed by the facility provider and pharmacist. PA-B stated medications given with other medications or around tube feedings can have side	F0684		05/19/2026

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F0684 SS = SQC-J	Continued from page 9 effects for R5 that include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. PA-B stated mismanagement of the g-tube with both tube feedings and medication administration could result in complications for R5. These complications could include harm, injury, and in worst case, death. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. PH-A stated R5 should be in an upright position during tube feedings and medication administration and up to an hour afterwards. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Additionally, levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. PH-A stated the medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission. During an interview on 4/9/26 at 11:22 a.m., licensed practical nurse (LPN)-B stated R5 had frequent nausea and vomiting. LPN-B stated they only track R5's bowel movements for output. LPN-B stated R5's emesis are not documented in R5's medical record. LPN-B described the process of administering medications via g-tube which did not include elevating head of bed during or after administration of medications or enteral feedings. During an interview on 4/9/26 at 11:42 a.m., registered nurse (RN)-B stated R5 was admitted to her unit at the hospital yesterday evening. Upon arrival at the hospital unit, R5 was nauseous and vomiting. R5 was given medication to resolve these symptoms. RN-B stated she had given R5 her normal medications this morning. RN-B stated the resident has not experienced nausea or vomiting since yesterday. RN-B stated R5 was able to take sips of water or clear liquids without experiencing nausea or vomiting.	F0684		05/19/2026

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F0684 SS = SQC-J	Continued from page 10 RN-B stated the resident must be sitting at least 30–45-degree angle during tube feeding and medication administration. RN-B stated if R5 receives tube feeding when not at the correct angle, she is at risk for nausea, vomiting, and abdominal pain. Additionally, she would be at a high risk for aspiration or aspiration pneumonia. During an interview on 04/09/2026 at 11:54 AM, PA-C stated frequently monitoring of calcium should be complete weekly until R5's calcium levels are stable, then monthly, then every six months. R5 has been on cinacalcet to manage her high calcium levels; she is on a consistent dose, but ongoing monitoring should still be weekly to bi-weekly. PA-C stated the most common symptoms of hypercalcemia included altered mental status, muscle cramps, and constipation. Nausea and vomiting aren't necessarily a symptom of hypercalcemia; but they are symptoms of the cinacalcet. PA-C stated if R5 was having nausea and vomiting, there is probably another cause for her symptoms. PA-C stated she would expect the facility staff to know the signs and symptoms of hypercalcemia, medication side effects, and how to properly manage the g-tube during tube feedings and medication administration. PA-C stated if R5's g-tube was mismanaged, R5 could be at risk for harm, increasing symptoms of nausea and vomiting and abdominal pain. Additionally, improper positioning during tube feeding and medication administration could result in serious risk for aspiration or other complications. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions; the pharmacy providing the medication will go through the interaction checker; the interaction warnings then get placed on the medication and the medication is delivered to the facility. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to	F0684		05/19/2026

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F0684 SS = SQC-J	Continued from page 11 the importance of accurate medication administration timing. During an interview on 4/7/26 at 3:15 p.m., vice president of success (VPS)-A stated nurses were educated about g-tubes annually and for regular competencies. VPS-A stated nurses can receive g-tube education sporadically; they didn't believe nursing staff were educated about the needs of R5 prior to her arrival. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated she believed the facility provided education to staff about g-tubes but couldn't find the specific education. DON stated she would expect education to be given for g-tubes, tube feeding administration, medication administration, g-tube complications, and g-tube side effects or symptoms. DON stated the facility had not cared for a resident with a g-tube in about a year. DON stated, generally g-tube education is annually, she did not provide g-tube education to staff about this R5 and her specific needs. DON stated it would have been beneficial to have educated staff specifically about R5 so staff could be prepared for any complications. On 4/14/26 at 10:22 a.m., a call was placed to the facility Medical Director; no return call received. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration. A facility policy titled Enhanced Barrier Precautions (EBP) dated 8/8/25, high-contact resident care activities include device care or use: feeding tubes. EBP should be followed when performing high-contact resident care activities. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. A facility policy titled Medical Director	F0684		05/19/2026

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F0684 SS = SQC-J	Continued from page 12 Responsibilities dated 4/22/25, the medical director's responsibilities include implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care. A Facility Assessment dated 7/11/25, training and skills unique to resident population: our nurses are trained in enteral feedings; our facility not only conducts a skill assessment during floor orientation of nurses and nursing assistants but also conducts monthly competencies of various skills to ensure that annual training occurs to keep skills honed. The IJ that began on 4/9/26 was removed on 4/10/26 when it was verified the facility implemented the following: -The facility immediately addressed R5's medical needs (nausea, vomiting, medications, and g-tube management) -The facility developed strategies to prevent g-tube complications during and after tube feedings and medication administration (staff education, g-tube education, and medication administration via g-tubes) -The facility reviewed and updated if needed g-tube policies including medication administration through a g-tube, condition monitoring, and fluid management -R5's medications were reviewed by a pharmacist and medication director to ensure appropriate timing is optimal to prevent nausea and vomiting -The facility developed processes to evaluate and monitor the side effects and effectiveness of medications -The facility educated staff on the policy and procedures to ensure consistency in the care of residents with g-tubes -The facility educated staff on the potential medication side effects and monitoring as well as the disease process for hypothyroidism, hyperparathyroidism (hypercalcemia). -The facility educated staff about tube feedings and	F0684		05/19/2026

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F0684 SS = SQC-J	Continued from page 13 the procedures and standards of practice of medication administration via a g-tube -Audit will be conducted by the DON or designee starting 4/10/26 on tube feeding administration, medication administration via g-tubes and positioning of residents with enteral nutrition or medications. Audits will be completed daily on varying shifts x7 days. Audits will continue no less than 3 times per week for 4 weeks or until substantial compliance is maintained. DON or designee will review facility charting daily to identify resident change in condition, to ensure proper documentation of assessments/evaluation and timely provider notification. These audits will be completed daily x7 days then with morning clinical 5 days per week for 8 more weeks or until substantial compliance is maintained. -Results of audits will be brought to Quality Assurance and Performance Improvement (QAPI) for review and recommendation -QAPI meeting on 4/10/26 to discuss with interdisciplinary team (IDT) and medical director to review findings and ongoing plan	F0684		05/19/2026
F0841 SS = F	Responsibilities of Medical Director CFR(s): 483.70(g)(1)(2) §483.70(g) Medical director. §483.70(g)(1) The facility must designate a physician to serve as medical director. §483.70(g)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 medical director had appropriate oversight of policies and procedures and ensured appropriate medical care was being provided for 1 of 1 (R5) resident who experienced complications from tube feedings and medication administration through a gastrostomy tube (g-tube). Refer to 684	F0841	1. R5 continues to reside at the facility. R5's orders for treatment including gastronomy tube feeding orders and care plan were reviewed by the Medical Director and the Director of Nursing on 05/07/2026 to ensure treatment meets clinical standards. 2. Current residents that receive medications and/or nutrition via gastronomy tube feeding have the ability to be affected by this alleged deficient practice. On 05/07/2026, the Medical Director in collaboration with Director of Nursing initiated an audit of all residents with enteral feeding tubes to validate that Licensed Nurses are following physician orders for administration and monitoring. No other residents were identified. 3. The medical director participates in scheduled Quality Assurance and Performance Improvement meetings to review care trends and support coordination of medical care. The Medical Director will now participate in a quarterly review during Quality Assurance and Performance Improvement meeting of high-risk clinical areas, including enteral nutrition, to ensure staff adherence to facility protocols starting Second Quarter 2026. Facility Licensed Nurses were re-educated on enteral feeding and medication administration starting 4/9/26.	05/19/2026

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F0841 SS = F	Continued from page 14 Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube). R5's current, undated care plan indicated the following: -urinary incontinence: report changes in skin integrity found during daily care -potential for pressure ulcer development: administer treatments as ordered, and monitor effectiveness follow facility policies/protocols for the prevention/treatment of skin breakdown monitor nutritional status monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth) -The need for a feeding tube/potential complications from that tube. R5 was to have no complications from the feeding tube. Staff were to administer formula and hydration and flushes per order. R5's care plan lacked identification of skin breakdown on R5's coccyx; further lacking goals and interventions for monitoring, treating, and documenting R5's actual skin breakdown. Additionally, R5's care plan lacked identification of R5's refusal of cares and treatments; further lacking goals and interventions to apply when R5 refused cares and treatments. R5's care plan lacked identification of R5's risk for fluid-volume imbalances; further lacking goals and interventions for monitoring, treating and documentation. R5's	F0841	Continued from page 14 4.Audits will be implemented by Director of Nursing or designee starting 04/10/26 on gastronomy tube feeding administration, medication administration via gastrostomy tube and positioning of resident with enteral nutrition or medications. Audits will be completed daily on varying shifts for 7 days and then 5 times weekly for 8 weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0841 SS = F	Continued from page 15 care plan lacked specific time requirements to elevate the head of the bed (HOB) to 30-45 degrees during and after tube feeding. Lastly, R5's care plan lacked specific symptoms, side effects, and monitoring of hypercalcemia, hypothyroidism, and hyperparathyroidism. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician's orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily R5's physician's orders lacked monitoring of electrolytes, monitoring accurate intake and output, managing fluid balance in relation to tube feedings and free water, medication interaction and interventions to prevent adverse effects, a process to monitor ongoing symptoms of nausea, vomiting,	F0841		05/19/2026

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F0841 SS = F	Continued from page 16 abdominal pain, and when staff should alert the provider when R5 refuses medications or treatments. During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 has a complicated gastrointestinal (GI) tract. R5 has hyperparathyroidism and this is the source of her hypercalcemia. R5 is no longer a surgical candidate to have her parathyroid removed, symptom management has been the primary direction of care. PA-A stated electrolyte imbalances will be an ongoing concern for R5. PA-A stated she didn't have plans to order follow up bloodwork to monitor electrolytes because she thought the consulting services (Nephrology, Endocrinology) would be monitoring them. PA-A stated she was not sure what the electrolyte monitoring schedule would be. PA-A stated she is unsure how often the nutrition team is working with R5 or how involved they are with her care. She is unsure if the nutrition team was monitoring specifically intake and output. During an interview on 4/7/26 at 12:02 p.m., director of nursing (DON) stated the medical director could be available during survey; he was seeing patients at his outpatient clinic. Further, he had been the medical director at the facility for a short time and this position at the facility was new to him; his first medical director position in long-term care. During a follow up interview on 4/8/26 at 2:39 p.m., PA-A stated she relied on the pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. PA-A had not directly communicated to the facility consultant pharmacist about R5's medication needs in relation to her tube feedings. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. PA-B stated she expected the facility providers to manage the calcium levels after discharge as she was a member of the hospital consulting service and infrequently sees R5. PA-B stated medication interactions should be managed by the facility provider and pharmacist; additionally, medication administration times should be assessed by the facility provider and pharmacist.	F0841		05/19/2026

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F0841 SS = F	Continued from page 17 During an interview on 04/09/2026 at 11:54 AM, PA-C stated frequently monitoring of calcium should be complete weekly until R5's calcium levels are stable, then monthly, then every six months. R5 has been on cinacalcet to manage her high calcium levels; she is on a consistent dose, but ongoing monitoring should still be weekly to bi-weekly. PA-C stated the facility providers are responsible for monitoring electrolytes, she would not be requesting electrolyte levels unless she saw R5 again as outpatient or in the hospital. During an observation on 4/10/26 at 3:18 p.m., the DON and vice president of success (VPS)-A stated they were waiting for the medical director to sign off on the immediate jeopardy (IJ) plan of correction; stating, "having a difficult time reaching him, he is seeing outpatients". The VPS stated she wasn't sure if he understood what an IJ was and the importance of lifting the IJ. On 4/14/26 at 10:22 a.m., a call was placed to the facility Medical Director; no return call received. A facility policy titled Medical Director Responsibilities dated 4/22/25, the medical director responsibilities included addressing issues related to coordination of medical care and implementation of resident care policies, ensuring the appropriateness and quality of medical care and medically related care, discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care.	F0841		05/19/2026
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by:	F0804	R1, R10, R15, and R30 continue to reside at facility. Executive Director attended resident council 04/24/2026, food committee was suggested and accepted by resident council. First food committee meeting will be held 05/12/26. Current residents that receive room trays and eat in the dining room have the potential to be affected. Executive Director/designee will re-educate Dietary service staff on the procedure for ensure proper food temperature prior to service of room trays starting on 05/09/2026. Facility implemented a plate warmer for entire service to assist in maintaining preferred temperature on 05/07/2026.	05/19/2026

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F0804 SS = E	Continued from page 18 Based on observation, interview and document review, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 4 of 4 residents (R1, R10, R15, R30) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchen. Findings include: On 4/8/26 at 1:34 p.m., an informal resident council meeting was held with R10, R15 and R30. The residents were asked, as part of the meeting, about bedtime snacks which prompted a conversation regarding food. R30 stated that she eats in the dining room for her meals and her food was frequently served cold. R30 stated this had been an issue for a long time and had talked to staff about this. R10 stated “today my food was ice cold even with the cover on it.” R10 stated the facility started putting covers on the food and it isn’t helpful. R10 stated he eats his meals in the dining room, and his meals are almost always cold when they should be hot. R10 stated he had talked to staff about this. R15 stated she eats in the dining room, and it had been an ongoing issue with getting served cold food when it should be hot. R1’s quarterly Minimum Data Set (MDS) dated 3/12/26, identified R1 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was independent with eating. During an interview on 4/6/26 at 2:56 p.m., R1 stated the food is cold and he must send it back a lot, it doesn’t matter if he eats in the dining hall or his room; the food is always cold. The facility had the hardest time keeping eggs, mashed potatoes, and beans warm. He stated he has told them so many times and, no one ever does anything about it. During an observation on 4/7/26 at 8:13 a.m., R1 was observed in the dining hall tasting his food (French toast), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R10’s comprehensive Minimum Data Set (MDS) dated 2/10/26, identified R10 had no cognitive impairment, demonstrated no hallucinations or	F0804	Continued from page 18 Executive Director, or designee, will conduct an audit of meal tray temperatures 3 times weekly for 5 weeks to ensure proper food temp prior to service. Executive Director, or designee, will audit for validation of improvement in food temperature palatability by interviewing 5 random residents weekly for 5 weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0804 SS = E	Continued from page 19 delusional thinking during the review period, and was independent with eating. During an observation on 4/7/26 at 8:18 a.m., R10 was observed in the dining hall tasting his food (French toast, eggs), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R15's quarterly Minimum Data Set (MDS) dated 2/12/26, identified R15 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required setup/clean up assistance with eating. During an interview on 4/7/26 at 8:40 a.m., R15 stated the food is cold sometimes, and doesn't know why they have such a hard time keeping the food warm, especially when residents are in the dining hall. She has stopped telling staff about the cold food, they don't do anything to change how they keep things hot. R30's quarterly Minimum Data Set (MDS) dated 3/36/26, identified R30 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required setup/clean up assistance with eating. During an interview and tray tasting on 4/7/26 at 12:37 p.m., dietary manager (DM)-A stated the plate covers in the dining hall, seen this morning, were just started today as a response to complaints of cold food. DM manager tasted food and noted the temperature of the food "seemed appropriate" to her. She does not attend resident council; she "might at some point" but right now she hasn't gone to any of the meetings. It is important to know how residents feel about the food so she can adjust based on their concerns. During an interview on 4/7/26 at 1:15 p.m., ombudsman (OM)-A stated residents at the facility started reaching out to her in October 2025 about the ongoing concerns with food temperatures and food being served cold. She also informed management about food menu options as well. During an interview on 4/13/26 at 10:04 a.m., DM-A	F0804		05/19/2026

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F0804 SS = E	Continued from page 20 stated residents frequently ask for foods to be reheated during meal services. Again, stated the lids on meal plates were started as a response to complaints about food temperatures; was unsure if they are helping with temperature or not. During an interview on 4/14/26 at 9:27 a.m., administrator stated she would expect residents to tell any facility staff about cold food. She stated she had not heard any concerns about cold food recently. Additionally, the plate lids weren't necessarily new, they just resumed the practice as an infection prevention method. Due to recent dietary staff changes and recommendations from the regional dietary staff, they had ceased this practice; but now had opted to bring it back. It is important to keep foods warm, so residents enjoy their food. A facility policy titled Food Temperatures dated 8/16/22, food must be cooked to appropriate temperatures, held appropriate temperatures.	F0804		05/19/2026
E0018 SS = D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.	E0018	No facility residents or staff were affected or identified as affected by practice. Current facility staff and residents have the potential to be affected. Emergency Operations Plan was reviewed and revised to include a system to track on-duty staff in the facility during emergencies by Executive Director by 05/06/2026 Executive Director, or designee, will re-educate current facility staff on this procedure starting on 05/09/2026. Executive Director, or designee, will complete a knowledge check on this procedure with 3 random staff weekly for 5 weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947

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E0018 SS = D	Continued from page 21 *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is NOT MET as evidenced by: Based on interview and policy review, the facility	E0018		05/19/2026

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E0018 SS = D	Continued from page 22 failed to develop and implement emergency preparedness policies and procedures that included a system to track the location of on-duty staff in the facility during an emergency. This had the potential to affect all residents at the facility and staff providing services at the facility. The facility's "Emergency Preparedness" three ring binder dated 1/14/26, lacked a policy and procedure to track staff during an emergency. During an interview on 4/14/26 at 9:21 a.m., administer stated the facility does not have a written policy for tracking staff, facility management “just knows what is going on and would provide direction to staff.”	E0018		05/19/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and care plan to ensure competency and safety with self-administration of medication for 1 of 1 resident (R20) observed to be self-administering medication in their room. Findings include: R20’s quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition. On 4/8/26 at approximately 7:20 a.m., R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A along with an inhaler after performing a respiratory assessment. RN-A prepared R20’s nebulizer and placed the mask on R20’s face. RN-A placed R20’s call light pad on her lap and instructed her to turn her call light on when the treatment was completed. R20 stated she always puts the light on when she was finished with the treatment.	F0554	R20 continues to reside at the facility. A self-medication evaluation was completed for the resident on 04/08/2026 by Assistant Director of Nursing. Current residents that self-administer aerosol nebulizer treatments have the potential to be affected. An audit was conducted by the Vice Present of Success to identify residents that require a self-medication evaluation for aerosol nebulizer treatments on 05/06/2026. Three other residents were identified. Self-medication evaluations were completed for residents identified. Director of Nursing, or designee, will conduct re-education with licensed nurses on the requirements for residents who self- administer nebulizer treatments to have a self-medication evaluation starting on 05/09/2026. Director of Nursing, or designee, will conduct an audit of residents utilizing nebulizer treatments for self-administration evaluations weekly for 5 weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations. Language? Do we state that we made corrections because we did have some that needed to be corrected. I would put that in there, because you need to get	05/19/2026

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F0554 SS = D	Continued from page 23 On 4/8/26 at 7:52 a.m., assistant director of nursing (ADON) told RN-A that she had removed R20 nebulizer mask and performed the post - respiratory assessment. R20's April medication/treatment administration report (MAR), printed 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR. The MAR lacked evidence that R20 was able to administer the medication independently after staff set up. R20's order summary report, dated 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The order summary report lacked an order or evidence that R20 was able to administer the medication independently after staff set up. R20's care plan, with an initiation date of 4/8/26 (after survey entrance) for self-administration of medications/treatments indicated "nurse to set up Neb and place mask on resident for resident to complete without supervision. Nurse to return to take mask off and complete prost respiratory assessment when treatment is complete." The care plan lacked evidence of identification of R20 being assessed and able to self-administer nebulizer prior to 4/8/26. R20's entire medical record was reviewed and lacked any assessment, physician order, or care planning which demonstrated R20 had been evaluated for their ability to self-administer medication.	F0554	Continued from page 23 orders do UDA etc.. too	05/19/2026

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F0554 SS = D	Continued from page 24 During an interview on 4/8/26 at 11:50 a.m., RN-A stated if a resident was cognitively aware, then the resident could be left alone with a nebulizer after set up. RN-A stated we know our residents and who can be left alone with nebulizer treatments. RN-A verified that R20 was left alone in her room with her nebulizer treatment this morning and this was the facility practice. RN-A stated R20 was able to push her call light when the treatment was completed to have the mask removed. RN-A stated a self-administration assessment should be completed for residents who self-administer medications. RN-A verified an assessment had not been completed for R20. During an interview on 4/8/26 at 11:56 a.m., ADON verified she had turned off R20's nebulizer treatment earlier today and removed her nebulizer mask. ADON verified R20 had been in her room alone. ADON stated if a resident was left in their room while completing a nebulizer treatment, it would be expected a self-administration of medication assessment would be completed as this would be self-administration of medication. ADON verified this had not been completed for R20. ADON stated she was going to complete an assessment. During an interview on 4/14/26 at 9:58 a.m., director of nursing (DON) stated the expectation would be if a resident was left with a nebulizer, a self-administration of medication assessment would be completed as it's important because the residents have to have the knowledge and understanding of what the medications is used for and why. DON stated they must be properly assessed. A facility policy titled Medication Administration Self-Administration by resident, reviewed 1/26, identified "residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Facilities must adhere to state specific laws and regulations." Furthermore, the document identified an assessment will be conducted to assess the resident's cognitive, physical and visual ability to carry out the responsibility.	F0554		05/19/2026

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F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F0580	R5 continues to reside at the facility. R5's POA was updated on 05/07/2026 of refusal of medications and cares. Care plan reviewed and updated. Current residents that choose to refuse medications and cares have the potential to be affected. Director of Nursing, or designee, will re-educate Certified Nursing Assistants on notification to nurses for resident refusal of cares. Director of Nursing, or designee, will re-educate licensed nurses on notification to responsible party and provider for refusals of medications and cares when applicable. Director of Nursing, or designee, will conduct an audit of resident documentation to identify refusal of medications and cares with appropriate notifications if applicable. This audit will be conducted 3 times a week for 5 weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0580 SS = D	Continued from page 26 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to notify the resident representative/Power of Attorney (POA) about refusal of care and/or treatment for 1 of 1 resident (R5) reviewed for notification of changes. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube). During a record review, R5's dismissal summary from the 2/12/26 hospitalization; the hospital physician stated, "R5 is unable to receive and evaluate information effectively and communicate decisions necessary to manager her health. I recommend that the provisions contained in her Power of Attorney for Health Care be activated". During a record review, R5's POA was activated at the facility upon return from the 2/12/26 hospitalization. R5's care plan failed to address R5's refusals of care; additionally, the care plan failed to provide direction, so staff know when to notify provider and POA about refusals of care and medications. R5's orders failed to address R5's refusals of care; additionally, the orders lacked direction, so staff knew when to notify the medical providers and POA	F0580		05/19/2026

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F0580 SS = D	Continued from page 27 about refusals of care and medications. During record review, R5 refused medications or treatment on the following dates after the POA was activated: -3/6/26: refusal to have blood drawn, no POA notification -4/6/26: refused weight measurements, no POA notification -4/7/26 at 5:16 a.m.: refused constipation medication, no POA notification -4/7/26 at 12:22 p.m.: refused constipation medication, no POA notification -4/7/26 at 8:58 p.m.: R5 stated her pain was worse, no POA notification -4/8/26 at 4:58 a.m.: R5 stated her pain had gotten worse, refused all bowel medications, no POA notifications During record review, there was no documentation R5's POA had been notified prior to leaving the facility to go to the Emergency Room (ER) on 2/12/26 after suffering a fall at the facility. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's POA was activated when she returned from the hospital on 2/22/26. DON stated the POA was activated when R5 was in the hospital because R5 had increasing periods of confusion and lack of understanding about her medical status. DON confirmed R5 has been intermittently refusing cares or treatments since the beginning of February. DON stated the facility doesn't notify the POA of refusals, probably should if the resident doesn't understand her condition or how the meds work. DON stated it is important to notify the POA about refusal of cares and treatments, so the POA knows the treatments R5 is or isn't receiving. Attempted phone call to speak with R5 POA made on 4/7/26 at 10:45 a.m. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated she was aware R5	F0580		05/19/2026

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F0580 SS = D	Continued from page 28 had intermittently been refusing medications. PA-A stated she would expect to be notified of ongoing refusals. PA-A stated R5 did not have an order to notify facility providers or POA of refusals of cares or treatments. PA-A stated notification to the POA is important, so the POA understands what treatments R5 isn't getting and why. Additionally, the POA may have some influence with R5 and encourage R5 to accept the cares and treatments. A facility policy titled Change in Condition of the Resident dated 9/20/2022, the facility should immediately inform the resident representative when there is a need to alter treatment or a need to discontinue an existing treatment due to adverse consequences, or to commence a new form of treatment.	F0580		05/19/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . .	F0605	R15 continues to reside at the facility. Orthostatic BP was obtained on 04/20/2026. No adverse effects were noted. Current residents requiring orthostatic BP monitoring related to medications have the potential to be affected. An audit was conducted by the Director of Nursing, or designee, and the pharmacy consultant to identify medications requiring orthostatic BP monitoring and pharmacy consultant offered recommendations to the primary care team as applicable on 05/06/2026. Director of Nursing, or designee, re-educated licensed nurses regarding medication side effect monitoring of orthostatic BP orders starting on 05/09/2026. Director of Nursing, or designee, will conduct an audit to ensure orthostatic blood pressures were completed as applicable. This audit will occur 3 times per week for 5 weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0605 SS = D	Continued from page 29 §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. §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;	F0605		05/19/2026

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F0605 SS = D	Continued from page 30 §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 appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 1 resident (R15) reviewed for unnecessary medication use and who consumed antipsychotic medication. Findings include: Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing).	F0605		05/19/2026

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F0605 SS = D	Continued from page 31 R15's quarterly Minimum Data Set (MDS), dated 2/12/26, identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review, R15's orders reflected orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April During a record review of R15's pharmacy review and recommendations indicated the following. In: -4/7/26: did not address orthostatic blood pressures not done in March 2026 or April 2026 -2/5/26: did not address orthostatic blood pressure not done in January 2026 -11/4/26: did not address orthostatic blood pressure not done in October 2026 During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her orthostatic blood pressure completed monthly. Additionally, if orthostatic blood pressures are ordered, it is her expectation they get completed monthly. When the consultant pharmacist performs the monthly review of medications, she would identify when orthostatic blood pressures aren't being completed and would put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible.	F0605		05/19/2026

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F0605 SS = D	Continued from page 32 During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. She would expect nursing to complete the orders as written and document why they weren't done. Since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record.	F0605		05/19/2026
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI	F0607	R32 continues to resident at the facility. Clinical assessments were completed and chart reviewed. A thorough investigation was conducted, and no adverse effects were noted. Current residents have the potential to be affected. Current residents were interviewed and skin assessed. No findings were noted. The Interdisciplinary Team held an Ad Hoc Quality Assurance and Performance Improvement meeting on 04/07/2026. Vice President of Success re-educated the Executive Director and the Director of Nursing on Reporting Requirements on 04/07/2026. Executive Director, or designee, conducted re-education with facility staff on the abuse, neglect, and misappropriation policy. The Vice President of Success, or designee, to	05/19/2026

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F0607 SS = D	Continued from page 33 program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility to implement policies and procedures to ensure the State agency (SA) was notified in a timely manner for allegations of abuse for 1 of 1 residents (R32) whose allegations were reviewed. Findings include: R32's significant change in status Minimum Data Set (MDS) assessment, dated 1/24/26, identified R32 had moderately impaired cognition, required maximum staff assistance with dressing, moderate assistance with transfers and displayed no hallucinations, delusions, or rejection of care behaviors. R32's care plan, initiated on 6/20/23, identified R32 as a vulnerable adult at risk for potential abuse due to Alzheimer's disease and identified facility staff are education on reporting abuse and facility staff will follow facility policy and procedures. During an observation on 4/6/26 at 2:08 p.m., R32 was observed playing Bingo in the dining room with other residents and staff. At 3:36 p.m., R32 was observed sitting in her wheelchair in her room. R32 stated she couldn't remember how long she had been at the facility and directed the surveyor to "ask her kids". R32 stated staff are "nice" and if she had any issues with staff, she "would know what to do" (as she raised her fist). During an interview on 4/7/26 at 12:32 p.m.,	F0607	Continued from page 33 conduct an audit of facility reported incidents and grievances to ensure that reporting is conducted per policy. Executive Director, or designee, will conduct 5 random interviews with staff members 2 times per week for 5 weeks to ensure an understanding of the appropriate response to reported abuse. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0607 SS = D	Continued from page 34 complainant (C)-A stated they had witnessed nurse aide (NA)-G telling R32 to “shut the [expletive] up” and “you need to stop acting like that.” C-A stated she stopped the administrator the day it happened as the administrator was walking passed and she spoke to her. C-A doesn’t recall exactly when this happened. C-A reported it to the State Agency as she “didn’t think anything at the facility was being done”. A message was left for R32’s power of attorney (POA)-A requesting a call back. A second message requesting a call back was left on 4/7/26 at 1:48 p.m. for R32’s POA-A. A return call was not received. Grievances for the past 6 months for the facility were reviewed. No grievances were provided indicating any abuse being investigated for R32. Allegations of abuse reported in the past 6 months requested. No allegations were provided involving R32. R32’s progress notes from 2/1/26 to 4/6/26 were reviewed. Progress notes lacked identification of abuse or abuse being investigated. During an interview on 4/7/26 at 4:51 p.m., the administrator stated the expectation was if any staff expected abuse, it would be reported to the administrator or the director of nursing immediately for further investigation. All staff are trained on abuse and the expectations of reporting abuse. If a staff member was talking to a resident, as stated above, that would be considered verbal abuse and would need immediate intervention which included reporting to the State Agency and a full investigation was to occur. She was not aware of this incident until today after surveyor interviewed C-A. She had not recalled if C-A stopped her in the hallway to talk to her or if C-A had told the administrator about any abuse concerns with R32. The administrator stated she had already begun a full investigation and filed a facility reported incident with the State Agency as it was a reportable incident as it would be considered an allegation of verbal abuse. During a follow up interview on 4/8/26 at 1:14 p.m., administrator shared the investigation that had been	F0607		05/19/2026

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F0607 SS = D	Continued from page 35 completed so far which included staff interviews, and review of R32's care plan, progress notes, trauma assessment, and skin checks, along with staff education, all notifications completed, and other resident interviews that had been provided at this time. During a follow up interview on 4/10/26 at 11:29 a.m., C-A stated they had gotten training on reporting abuse prior to initially reporting abuse. C-A stated since 4/7/26, they have gotten additional training on what to say when reporting abuse. C-A stated when they had stopped administrator in the hallway to report concerns of abuse, they didn't tell administrator they had actual concerns about alleged abuse. C-A stated she told the administrator they wanted to talk about R32 and NA-G but didn't tell the administrator what the concerns were. C-A stated she didn't follow back up with the administrator to explain she had concerns about alleged abuse. During an interview on 4/13/26 at 11:38 a.m., NA-G stated they had received education on abuse which included definitions and examples of abuse. The facility had called her in the last couple of days to talk about the incident with R32. During an interview on 4/14/26 at 9:57 a.m., director of nursing (DON) stated the expectation was if abuse was suspected, staff would intervene and communicate to management, and it would be reported immediately. During an interview on 4/14/26 at 11:27 a.m., administrator stated they developed a new procedure following the above noted abuse allegation, as it was determined staff needed additional education on how to report abuse, specifically need to make sure "they are saying what they are trying to say". The administrator stated they are also implementing another step that will involve staff writing a statement to ensure nothing gets lost or was missed as it was with this incident. The facility Abuse, Neglect, and Exploitation policy, reviewed 7/15/22, indicated a statement of the facility was to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation	F0607		05/19/2026

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F0607 SS = D	Continued from page 36 and misappropriation of resident property. The policy defined abuse as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.” Furthermore, “"Verbal Abuse" means the use of oral, written or gestured communication or sounds that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.” New employees were to be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation and existing staff were to receive annual education through planned in-services and as needed, which included the reporting process for abuse. The facility was to report all alleged violations to the administrator, State Agency, Adult Protective Serves and to all other required agencies within the specified timeframe.	F0607		05/19/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F0628	R5 continues to reside at the facility. R39 no longer resides at facility. Residents that have been transferred or discharged have the potential to be affected. A 30 day look back audit was conducted by the Social Service Director for discharged residents to ensure the notification of ombudsman occurred 05/08/2026. Vice President of Success re-education the Social Services Director and the Executive Director on the Discharge process including the Ombudsman notification on 05/06/2026. Executive Director, or designee, will audit notifications to the ombudsman 1 time weekly for 5 weeks, or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0628 SS = D	Continued from page 37 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F0628		05/19/2026

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F0628 SS = D	Continued from page 38 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as	F0628		05/19/2026

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F0628 SS = D	Continued from page 39 the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both	F0628		05/19/2026

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F0628 SS = D	Continued from page 40 prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the Office of the State Long-Term Cate (LTC) Ombudsman for 2 of 2 residents (R5 and R39) reviewed for hospitalizations and discharges. Findings include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5’s face sheet indicated R5 was originally admitted to the facility on 1/16/26. R5 was hospitalized on 2/12/26 and 3/6/26. R5's Progress notes lacked any communication with the ombudsman after each hospitalization. Review of the notices to the Ombudsman, provided by the facility, identified the notice sent on 3/8/26 did not include R5’s hospitalizations. During an interview on 4/7/26 at 12:52 p.m., ombudsman (OM)-A stated she had received a notification from the facility on 3/8/26; this notification contained information about hospitalizations, transfers, and discharges from November and December. OM-A stated she has not received any other notifications for the months of January, February, and March. During an interview on 4/10/26 at 10:22 a.m., social services (SS)-A stated he is responsible for sending notification to the ombudsman about hospitalizations, transfers, and discharges; these notifications are supposed to be sent monthly. SS-A confirmed he is “behind a little with submitting” the	F0628		05/19/2026

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F0628 SS = D	Continued from page 41 notifications to the ombudsman. SS-A stated ombudsman notification are important, so residents have advocate if they feel they have been wrongly hospitalized, transferred, or discharged. R39's admission Minimum Data Set (MDS) assessment, dated 2/17/26, identified R39 had moderately impaired cognition and required moderate to maximum staff assistance with activities of daily living (ADLs). R39's diagnoses included: displaced fracture of the base of the left femur, hip fracture, coronary artery disease (heart disease), heart failure (heart not functioning properly), hypertension (high blood pressure), and diabetes mellitus (condition where the body's ability to manage glucose is impaired). R39's progress dated 2/11/26 to 3/6/26 identified a progress note dated 2/11/26 at 10:53 a.m., indicated R39 was admitted to the facility. Another progress noted dated 3/6/26 at 5:43 p.m., indicated R39 discharged home to a new apartment from the facility. The progress notes lacked any communication with ombudsman during planning process of R39's discharge. Review of the notices to the Ombudsman, provided by the facility, identified a notice sent on 3/8/26 did not include R39. During an interview on 4/13/26 at 9:56 a.m., social services (SS)-A stated that he had worked with R39 for her planned discharge. SS-A stated R39 had a case manager who also assisted with the discharge. SS-A stated he had not coordinated with the ombudsman or updated the ombudsman that R39 was planning to discharge prior to discharge. SS-A was unsure if he updated the ombudsman after R39 discharged. If R39 was not on the list provided to surveyors that was sent to the ombudsman's office the beginning of March, then the ombudsman had not been notified. A facility policy titled Transfer and Discharge (including AMA), reviewed 7/15/22, identified for non-emergency transfer or discharges which were initiated by the facility and return not anticipated, a copy of notice shall be provided to a representative of the Office of the State Long-Term Care Ombudsman. Furthermore, instances of emergency transfers/discharges, the social services director or	F0628		05/19/2026

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F0628 SS = D	Continued from page 42 designee, shall provide notice of transfer to a representative of the State Long-term Care Ombudsman via monthly list.	F0628		05/19/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care	F0656	R5 continues to reside at the facility. R5's care plan was reviewed and updated to be person-centered on 04/10/2026. Current residents who require a person-centered care plan have the potential to be affected. Current residents care plans were reviewed to ensure comprehensive care plan for major diagnosis. Vice President of Success, or designee, will re-educate interdisciplinary team members who are responsible for writing care plans and Licensed Nurses on the facility's policy and procedure for developing Comprehensive Care Plans starting 05/09/2026. Director of Nursing/ Designee with audit new and readmissions to ensure comprehensive care plans are completed in a timely manner. This audit will be completed weekly x5 weeks. In addition, residents' care plans to be reviewed quarterly per facility policy. The results of the audit will be brought to Quality Assurance and Performance Improvement meeting for review and recommendations.	05/19/2026

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F0656 SS = D	Continued from page 43 plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement a person-centered care plan for 1 of 1 resident (R5) reviewed for comprehensive care plans. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube). R5's hospital discharge summary dated 2/25/26 noted the following: -Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air -Skin problem to left heel: clean, dry, intact: treatment offloading and open to air -Skin problem to right heel: clean, dry, intact: treatment open to air R5's current, undated care plan indicated the following: -urinary incontinence: report changes in skin integrity found during daily care -potential for pressure ulcer development: administer treatments as ordered, and monitor effectiveness follow facility policies/protocols for the prevention/treatment of skin breakdown	F0656		05/19/2026

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F0656 SS = D	Continued from page 44 monitor nutritional status monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth) -The need for a feeding tube/potential complications from that tube. R5 was to have no complications from the feeding tube. Staff were to administer formula and hydration and flushes per order. R5’s care plan lacked identification of skin breakdown on R5’s coccyx; further lacking goals and interventions for monitoring, treating, and documenting R5’s actual skin breakdown. Additionally, R5’s care plan lacked identification of R5’s refusal of cares and treatments; further lacking goals and interventions to apply when R5 refused cares and treatments. R5’s care plan lacked identification of R5’s risk for fluid-volume imbalances; further lacking goals and interventions for monitoring, treating and documentation. R5’s care plan lacked specific time requirements to elevate the head of the bed (HOB) to 30-45 degrees during and after tube feeding. Lastly, R5’s care plan lacked specific symptoms and side effects of hypercalcemia, hypothyroidism, and hyperparathyroidism. R5’s February, March, and April 2026 treatment administration record (TAR) noted to “Monitor Mepilex dressing to buttock daily and change every 3 days and as needed when soiled” beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 is a complicated resident due to her multiple medical problems including hypercalcemia, hypothyroidism, hyperparathyroidism, nausea, vomiting, and gastrectomy tube (g-tube) a device surgically inserted through the belly directly into the stomach to deliver nutrition, fluids, and medications). PA-A stated she would expect to see a care plan for each of these areas.	F0656		05/19/2026

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F0656 SS = D	Continued from page 45 During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5 had a Stage I pressure ulcer; her care plan did not reflect any goals or interventions to care for and prevent worsening of the pressure ulcer. DON confirmed R5's care plan only indicated a risk for pressure ulcers; should have identified the actual Stage I pressure ulcer and contain interventions such as encouraging position changes, how often to monitor the coccyx, and treatment directions. The DON stated R5's care plan did not include information about her refusal of cares and treatments. The DON stated this care plan would identify the interventions that could have worked to encourage R5 to follow care and treatment orders. The DON stated R5 did not have a fluid-volume care plan. This care plan would be beneficial so staff could monitor and document fluids; this would be important for the resident since she had a G-tube. The DON stated this resident is complicated, R5's care plan should probably have more detail about her medical conditions so staff could be aware of the symptoms or side effects. The DON stated a complete and comprehensive care plan is important so facility staff could identify, monitor, and treat R5's medical issues. During an interview on 4/8/26 at 2:39 p.m., PA-A stated she would expect a complete and comprehensive care plan; a comprehensive care plan allows the facility to adjust cares and interventions based on R5's needs and desire for treatment. PA-A stated she would specifically expect to see a care plan for skin breakdown, fluid intake-output, refusals of care, and tube feeding care. PA-A stated care plans are important because they can be tied into the treatment and medication tasks the facility staff perform; without a specific care plan, staff might not know how to provide specific types of care. A facility policy titled Comprehensive Care Plan dated 9/23/2022, the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. These objectives will be used to monitor the residents' progress. Alternative interventions will be documented, as needed.	F0656		05/19/2026

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F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure professional standards of practice were followed during medication administration for 1 of 1 resident (R5) reviewed for gastrostomy tube (g-tube) medication administration. Findings include: According to the American Society for Parenteral and Enteral Nutrition article, “Medication via Enteral Feeding Tubes: A Clinician's Guide”, located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water (sterile or distilled) separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Lastly, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube).	F0658	R5 was hospitalized 4/8/26 and registered nurse assessment completed upon re-admission on 4/9/26 which included a dehydration risk screener and a head-to-toe assessment. The Registered Dietician completed a Nutrition Assessment, which included estimated fluids needs. Consultant pharmacist or designee was consulted on 04/09/26 and medications were reviewed to ensure prior timing of medications in association with other medication interactions and indications (with food or fasting). Registered Dietician reviewed resident tube feeding and fluid orders on 4/9/26 and verified free fluid orders including water for medication pass. Director of Nursing consulted Primary Care physician on 04/10/26 with consultant pharmacist recommendations regarding timing of medications and Registered Dietician recommendations. Primary Care Physician contacted on 4/10/2026 regarding need for continued labs and at what frequency. Care plan updated 4/10/2026 to reflect observation for signs and symptoms of hyperparathyroidism, hypothyroidism, and at risk for fluid volume deficit and at risk for constipation. Care plan also updated to include both monitoring of intake and output, which would include estimation of amount of emesis, if/when emesis occurs. Current residents that receive medications and/or nutrition via tube feeding have the potential to be affected. No other residents were identified. Current residents that receive medications and/or nutrition via tube feeding have ability to be affected by this alleged deficient practice. Facility Policies on Medication administration, Enteral Medication Administration, Hydration, verifying placement of tube feeding, and change of condition policy were reviewed by Interdisciplinary Team on 4/9/2026. Facility Licensed Nurses will be re-educated by Director of Nursing or designee on identified policies and identified medication side effects and signs symptoms of hypothyroidism and hyperparathyroidism starting 4/9/2026 and will be completed prior to start of next scheduled shift. Facility licensed and non-licensed nursing staff were re-educated on positioning importance and elevating head of bed on residents receiving enteral medications and nutrition, starting 04/09/2026, occurring prior to start of next scheduled shift. Nursing assistants re-educated on completion of STOP and WATCH tool and notifying nurse for changes in condition, including subtle changes in condition. Licensed Nurses re-educated on how to respond to alerts, which includes assessment/data gathering and notification of provider when	05/19/2026

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F0658 SS = D	Continued from page 47 R5's care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's provider orders included tube feedings (Vital Advanced Formula at 100ml/hr for 13 hours) via g-tube. R5 was to receive 150ml free-water flush in g-tube every 4 hours, including during tube feeding. R5 was to receive 150ml of water flush in her g-tube after medication administration for the AM medication pass. R5's medication orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1mg via g-tube daily -apixaban (blood thinner) 2.5mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5mg via g-tube twice daily -senna (laxative) 8.6mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10ml daily -ascorbic acid (vitamin C) 500mg via g-tube daily Review of the April 2026, Medication administration Record (MAR) identified R5's last tube feeding ended at 5:42 AM.	F0658	Continued from page 47 indicated. This eINTERACT/STOP and WATCH education will be completed by the Director of Nursing, or designee, and will be initiated on 4/10/2026 and will be completed prior to next scheduled shift. Staff were notified of need for re-education via a message on the electronic scheduling system. Knowledge check will be completed with Certified Nursing Assistants to validate understanding of STOP and WATCH/change in condition reporting process and a knowledge check will be completed with Licensed nurses regarding tube feeding and change in condition assessment/data gathering. Ad Hoc Quality Assurance and Performance Improvement meeting completed on 04/10/2026 with Interdisciplinary Team and Medical Director to review findings and plan. Audits will be implemented by Director of Nursing or designee starting 04/10/26 on tube feeding administration, medication administration via gastrostomy tube and positioning of resident with enteral nutrition or medications. Audits will be completed daily on varying shifts x 7 days. Audits will continue no less than 3 times per week for 4 weeks or until substantial compliance is maintained. Director of Nursing or Designee will review facility charting daily to identify resident change in condition, to ensure proper documentation of assessment/evaluation and timely provider notification. These audits will be completed daily x7 days, then with morning clinical 5 days per week for 8 more weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0658 SS = D	Continued from page 48 During observation and interview on 4/8/26 at 09:39 a.m., registered nurse (RN)-A prepped R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when R5 had their last tube feeding completed. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. RN-A failed to ensure the head of the bed was at 30-45 degrees, with the bed remaining at approximately 10 degrees while R5 was observed to be slouched down in the bed. RN-A stated R5 received a 30 ml water flush before medication administration, 30 ml water flush in between each medication, and a 150 ml water flush at the end of the medication administration. During medication administration, RN-A diluted each medication with approximately 2 ml of tap water, which failed to dilute the medication enough to allow it to pass through the g-tube. When RN-A put the medication into the barrel of syringe attached to the g-tube, the medication was not diluted enough to flow. RN-A then began adding additional unmeasured amounts of tap water into the g-tube and continued to add water until the medication would flow; 2 medications she added additional tap water had to use the syringe plunger to apply pressure to advance the medication. During medication administration process, R5 stated she was having increased nausea and abdominal pain. RN-A failed to recognize R5 was still not at the correct positioning and was now experiencing side effects of incorrect positioning. During administration RN-A failed to flush the g-tube between medications levothyroxine and metoprolol. RN-A was unsure what effect this could have on R5. After administration was completed, RN-A failed to once again, to ensure R5's HOB was set to 30-45 degrees. During the above observation, it was identified RN-A failed to: Identify the medication, levothyroxine, had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension). Identify prednisone should be given with food or	F0658		05/19/2026

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F0658 SS = D	Continued from page 49 that R5's iron-multivitamin suspension should be given on an empty stomach. prep the iron-multivitamin suspension with 15 ml and instead prepped with 20 ml of water. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) (gloves and gown?) prior to providing care. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she was unsure how much additional water she had added to dilute medication enough to flow through tube; she guessed it was approximately 5 ml. RN-A stated with the complete medication administration and water flushes; R5 had received approximately 450 ml of liquid. RN-A stated she had not had g-tube education for "some time". RN-A stated she should probably have sat R5 upright in bed, but she looked "ok", so she administered the medication. RN-A stated the facility had not had a resident that required tube feedings or had a g-tube for about a year or year and a half. RN-A stated she thought it was fine to have used tap water for the medication dilution and water flushes and could not state what other types of water could be used for medication administration using a g-tube. RN-A stated she had been taking care of R5 since her admission in January. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. PA-A stated she expected the nursing team to follow the standard of practice when administering medication via g-tube, including elevating the HOB at 30-45 degrees during and after tube feeding and medication administration and using sterile water to dilute medications and water flushes. Additionally, she was unsure of the amount of water needed to dilute the medication; however, she would anticipate this to be approximately 5-10ml of water and the nurse should be keeping track of this to adjust the water flushes during administration. PA-A stated abdominal pain and increased nausea, and vomiting could be side effects of having the HOB less than 30 degrees.	F0658		05/19/2026

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F0658 SS = D	Continued from page 50 During an observation on 4/8/26 at 3:09 p.m., R5 was seen being taken via ambulance to the local emergency room; RN-A stated R5 was sent to the emergency room due to vomiting since receiving medications this morning. During an interview on 4/9/26 at 8:53 a.m., physician assistant (PA)-B stated R5 should be seated at a 30–45-degree angle, at minimum, for tube feeding and medication administration and remain upright for 30-60 minutes after completion. PA-B stated medications should be given as ordered, especially right dose. PA-B stated after crushing medications, nurses should follow national standards for administering medication, to include medication dilution and free water flushes. During an interview on 4/14/26 at 10:29 a.m., director of nursing (DON) stated she expected R5 to have received the correct ordered dose of medication. The correct medication dilution should have been with 15 ml of sterile water, not tap water; to ensure the medication didn't get clogged in the tube. The HOB should be elevated to about 30-45-degrees for tube feedings and medication administration; to prevent aspiration, pain, and discomfort during feedings or medication administration. The DON stated she expected nurses to know what side effects R5 had related to receiving medications via g-tube, abdominal discomfort, nausea, vomiting, and constipation. Facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, failed to identify practice standards for medication administration and tube feeding administration. A facility policy titled Medication Administration dated 1/26, medication dose should be verified three times before administration; when pulling medication, when dose is prepared, and before dose is administered. If a resident is tube-fed, staff were to ensure medications were crushed finely to prevent clogging. Medications were to be administered in accordance with written orders. Timing must align with manufacturer's specifications. Review of the 8/10/22, Verifying Placement of Tube Feeding policy identified before beginning a feeding, flushing the tube, or administering a medication via	F0658		05/19/2026

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LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947

(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
F0658 SS = D	Continued from page 51 a feeding tube, proper placement and functioning of the tube was to be verified. A resident's HOB was to be kept elevated, at a minimum, of 30 degrees at all times to prevent aspiration and pneumonia. To verify tube placement, staff were to check that the enteral retention device was properly attached to the abdominal wall by gently tugging on the tube and noting the marking on the tube. Staff were to notify the supervisor and/or physician of abnormal findings. Next, they were to measure the length of the tube from insertion site to the tip and record the length prior to feedings etc per facility policy. If staff were unable to confirm placement, they were to notify the supervisor and/or physician. Staff were to also measure the pH (acidity) of gastric secretions by drawing back on the syringe slowly to obtain 5-10 ml of stomach aspirate, place into a cup, and dip a pH strip into the aspirate. Gastric fluid should usually have a pH of 5 or less. Staff were to then flush the tube with 30 ml of water or per physician's order. Staff were to monitor residents for complications such as respiratory distress which may indicate aspiration or tube dislodgement. A facility job description titled Registered Nurse dated 2/14/2018, the registered nurse (RN) adheres to the standards of care for the area, manages environment to maintain resident safety, and supervises the resident care activity. RNs prepares and administers medications and performs treatments as ordered by the physician.	F0658		05/19/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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.	F0686	R5 continues to reside at the facility. A skin assessment was completed for R5. R5's actual/at risk for skin impairment care plans reviewed and updated. Current residents who are at risk for skin impairments have the potential to be affected. Current residents skin care plans were reviewed to ensure preventive interventions, monitoring, and orders are in place as applicable. Vice President of Success, or designee, will re-educate the clinical IDT members and licensed nurses on the requirement to ensure residents who are at risk for skin breakdown have an at risk for skin impairment care plan with appropriate interventions starting on 5/09/26. Licensed Nurses will be re-educated on the Pressure Injury and Non-pressure Injury Policy starting on 05/09/2026.	05/19/2026

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F0686 SS = D	Continued from page 52 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to monitor and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 1 of 1 resident (R5) reviewed for pressure ulcers. Findings Include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). R5's hospital discharge summary dated 2/25/26 noted the following: -Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air -Skin problem to left heel: clean, dry, intact: treatment offloading and open to air -Skin problem to right heel: clean, dry, intact: treatment open to air	F0686	Continued from page 52 Director of Nursing, or designee, will conduct an audit of 5 random residents who are at-risk for skin impairment to ensure preventive interventions are in place weekly for 5 weeks. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0686 SS = D	Continued from page 53 R5's care plan indicated the following: -urinary incontinence: report changes in skin integrity found during daily care -potential for pressure ulcer development: -administer treatments as ordered, and monitor effectiveness -follow facility policies/protocols for the prevention/treatment of skin breakdown -monitor nutritional status -monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth) R5's care plan lacked resident-specific interventions to prevent or mitigate pressure ulcers that included reposition changes, specialty pressure redistribution boots for heels, toileting program to prevent wet skin, specialty padding for chairs, and barrier protection creams. R5's February, March, and April 2026 treatment administration record (TAR) noted to "Monitor Mepilex dressing to buttock daily and change every 3 days and as needed when soiled" beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. R5's weekly skin assessments were completed 1/23/26, 1/30/26, 2/7/26, 3/3/26, 3/27/26, and 4/3/26, stating no skin issues. The weekly skin assessments failed to identify R5's coccyx stage I pressure injury, ongoing monitoring, and ongoing assessments. During an interview on 4/7/26 at 11:31 a.m., R5 stated she does have breakdown on her buttocks. R5 stated the staff at the facility put a covering over it every few days; sometimes it gets wet when she is incontinent, so they must replace it then too. R5 is unsure if the skin breakdown is better or worse because she can't see it. Sometimes her buttocks	F0686		05/19/2026

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F0686 SS = D	Continued from page 54 and her heels get sore; but she doesn't get up much so that won't change much. R5 doesn't remember if facility staff have asked her to reposition herself or offered to assist her to reposition. R5 prefers to sit up because she gets nauseous a lot. During an observation and interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated she was not aware R5 had any skin breakdown on her coccyx and awas unaware of fragile skin on her heels. PA-A and the director of nursing (DON) evaluated R5's coccyx, PA-A stated this was a stage I pressure ulcer. Additionally, the mepilex dressing on the coccyx was not placed correctly to prevent further skin breakdown. PA-A stated she would expect to see a pressure ulcer care plan with interventions to prevent further breakdown. During an interview on 4/7/26 at 12:02 p.m., DON stated R5 came back from the hospital in February with a stage I pressure ulcer. DON stated the facility ordered the mepilex for her coccyx, but she acknowledged the facility did not update the care plan or TAR to include interventions to prevent or mitigate skin breakdown. DON was unaware about the fragile skin on her heels; acknowledged R5 should have had interventions in place to prevent pressure injuries of her heels. During a follow up interview on 4/7/26 at 3:25 p.m., DON stated R5's care plan was appropriate when she first arrived in January; but should have been updated upon her return in February to include interventions to prevent or mitigate skin breakdown. DON confirmed R5 had a current stage I pressure ulcer. Additionally, the DON confirmed the facility had not been assessing the coccyx weekly since 3/4/26. The DON stated it is important to implement a complete resident-specific care plan to prevent additional skin breakdown and alterations. A facility policy titled Pressure Injuries and Non-Pressure Injuries dated 7/20/22, the facility will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing,	F0686		05/19/2026

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F0686 SS = D	Continued from page 55 prevent infection, and prevent further development of pressure injuries/impaired skin integrity.	F0686		05/19/2026
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to monitor daily oral intake and daily output; additionally, the facility failed to develop a system to monitor and assess daily intake and output for 1 of 1 resident (R5) reviewed who required nutritional and hydration support via a gastrostomy tube (g-tube). Findings Include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 required hydration and nutrition via a feeding tube (g-tube). R5's current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing) requiring the placement of a gastrostomy tube (g-tube) for nutrition and medication administration.	F0693	R5 was hospitalized 4/8/26 and registered nurse assessment completed upon re-admission on 4/9/26 which included a dehydration risk screener and a head-to-toe assessment. The Registered Dietician completed a Nutrition Assessment, which included estimated fluids needs. Registered Dietician reviewed resident gastrostomy tube feeding and fluid orders on 4/9/26 and verified free fluid orders including water for medication pass. Director of Nursing consulted Primary Care physician on 04/10/26 with consultant pharmacist recommendations regarding timing of medications and Registered Dietician recommendations. Care plan updated 4/10/2026 to reflect observation for signs and symptoms of hyperparathyroidism, hypothyroidism, and at risk for fluid volume deficit and at risk for constipation. Care plan also updated to include both monitoring of intake and output, which would include estimation of amount of emesis, if/when emesis occurs. Current residents that receive nutrition and hydration via gastrostomy tube feeding have the potential to be affected. No other residents were identified. Facility Policies on Hydration, verifying placement of gastrostomy tube feeding, and change of condition policy were reviewed by Interdisciplinary Team on 4/9/2026. Facility Licensed Nurses will be re-educated by Director of Nursing or designee on identified policies and identified medication side effects and signs symptoms of hypothyroidism and hyperparathyroidism starting 4/9/2026 and will be completed prior to start of next scheduled shift. Facility licensed and non-licensed nursing staff were re-educated on positioning importance and elevating head of bed on residents receiving enteral medications and nutrition, starting 04/09/2026, occurring prior to start of next scheduled shift. Nursing assistants re-educated on completion of STOP and WATCH tool and notifying nurse for changes in condition, including subtle changes in condition. Licensed Nurses re-educated on how to respond to alerts, which includes assessment/data gathering and notification of provider when indicated. This eINTERACT/STOP and WATCH education will be completed by the Director of Nursing, or designee, and will be initiated on 4/10/2026 and will be completed prior to next scheduled shift. Staff were notified of need for re-education via a message on the electronic	05/19/2026

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F0693 SS = D	Continued from page 56 R5's care plan dated 1/26/26 indicated R5 required tube feeding, hydration, and flushes per order, check tube placement prior to meds and feedings, elevating head of bed 30-45 degrees, care of tube per orders, and report signs of aspiration or intolerance of feeding. R5's care plan lacked identification for a risk in decreased hydration, lacked the specific signs and symptoms of aspiration, lacked resident-specific interventions to mitigate complications when using the g-tube, and lacked guidance and collaboration for monitoring fluid balance and imbalance. R5's current physician orders included tube feedings (Vital Advanced Formula at 100 milliliters (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150ml of water flush in g-tube after medication administration for the AM medication pass. R5's orders lacked a clear monitoring system for intake and output including urine output, emesis amounts, amount of bowel movement, and amount of oral intake. R5's nutrition assessments dated 1/22/26, 3/2/26, and 3/16/26: section 30 failed to accurately identify how much oral intake the resident received (to adjust free water amounts), section 36 failed to identify gastrointestinal (GI) concerns such as nausea and vomiting, and section 44 failed to identify the amount of emesis the resident experienced (to know when to adjust free water amounts). R5's electronic medical record lacked collaboration, assessments, and outcome about who would be overseeing and managing daily intake and output in relation to the amount of tube feeding and free water flushes R5 should have received to maintain adequate fluid and nutrition. Additionally, the medical record and testing lacked collaboration and follow up to monitor and assess previously known electrolyte imbalances (high calcium, low potassium, high sodium) with a previously low Albumin level of 3.0 (could indicate malnutrition) on 1/6/26. During an interview on 4/7/26 at 11:31 a.m., R5 stated they give her a lot of water during the day and then in the evening they start her tube feedings;	F0693	Continued from page 56 scheduling system. Knowledge check will be completed with Certified Nursing Assistants to validate understanding of STOP and WATCH/change in condition reporting process and a knowledge check will be completed with Licensed nurses regarding gastrostomy tube feeding and change in condition assessment/data gathering. Ad Hoc Quality Assurance and Performance Improvement meeting completed on 04/10/2026 with Interdisciplinary Team and Medical Director to review findings and plan. Audits will be implemented by Director of Nursing or designee starting 04/10/26 on gastrostomy tube feeding administration, medication administration via gastrostomy tube and positioning of resident with enteral nutrition or medications. Audits will be completed daily on varying shifts x 7 days. Audits will continue no less than 3 times per week for 4 weeks or until substantial compliance is maintained. Director of Nursing or Designee will review facility charting daily to identify resident change in condition, to ensure proper documentation of assessment/evaluation and timely provider notification. These audits will be completed daily x7 days, then with morning clinical 5 days per week for 8 more weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0693 SS = D	Continued from page 57 she thinks “it is just too much liquid for [her] to handle”, and she gets nauseous and vomits at times. R5 stated she wasn’t sure who kept track of all that liquid going in, but she felt like it was too much. During observation and interview on 4/7/26 at 11:47 p.m., physician assistant (PA)-A had entered R5’s room to evaluate her pressure ulcer; upon entering, the resident was vomiting and handed the emesis bag to the nurse. The emesis bag contained approximately 300ml of vomit; a later record review noted this amount was not documented in a treatment administration record (TAR) nor a progress note. Additionally, the TAR and task list did not contain an option to document any output. PA-A stated R5’s GI tract was complicated due to her hyperparathyroidism resulting in high calcium levels; symptom management is the primary treatment option as R5 is no longer a surgical candidate. She was “not aware how often nutrition is involved with her care”. She was not actively monitoring daily intake and output. She stated she also did not have any laboratory orders for blood draws to assess electrolyte imbalances; “the teams in the hospital might be managing that.” During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5’s tube feeding care plan should have been more resident-specific to include aspects of care such as head-of-bed elevation, medication administration, g-tube complications, and symptoms and side effects. The DON acknowledged they should have been monitoring R5’s intake and output more closely, especially the emesis amounts. Fluid balance is important for R5 since she is receiving tube feedings and free water flushes. Staff needed to make sure her hydration and nutrition are adequate. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration.	F0693		05/19/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F0695	R16 No longer resides at the facility. R16’s oxygen tubing was discarded, and new tubing was provided and dated on 04/10/2026. R16’s orders were reviewed to ensure changing of oxygen tubing order was present on 04/10/2026.	05/19/2026

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F0695 SS = D	Continued from page 58 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 oxygen tubing was changed according to standards of care to prevent respiratory infections for 1 of 1 residents (R16) who required oxygen for chronic respiratory failure with hypoxia (a condition where the lungs are unable to adequately oxygenate the blood). Findings include: R16's quarterly Minimum Data Set (MDS) assessment, dated 2/11/26, identified R15 had intact cognition with no hallucinations, delusions, or rejection of care with admission date of 11/21/25. R16's admission record indicated on 2/18/26, R16's primary diagnosis was end stage renal disease with secondary diagnoses of chronic respiratory failure with hypoxia, biventricular heart failure (heart not working correctly), dependency on supplemental oxygen, unspecified right bundle-branch block (condition where electrical conduction in the heart is impaired), thoracis aortic ectasia (dilation or bulging in aorta in the chest), and atrial fibrillation (heart not beating correctly). Additional secondary diagnosis, dated 1/21/25, included: pulmonary hypertension (high blood pressure in the arteries of the lungs that strains the heart), and pleural effusion (buildup of excess fluid between the layers of the pleura surrounding the lungs). During an interview on 4/6/26 at 4:08 p.m., R16 was observed to be sitting in his wheelchair receiving oxygen via nasal canula from an oxygen concentrator at 2 liters(l)/minute. R16's oxygen tubing did not have a date or label on it. R16 was observed to have a portable oxygen tank on the back of his wheelchair with the oxygen tubing with nasal cannula attached wrapped around it with no date on it. R16 was not sure when the oxygen tubing had been changed.	F0695	Continued from page 58 Current residents who receive oxygen therapy have the potential to be affected. An audit was conducted by the Director of Nursing, or designee, to identify current residents who receive oxygen therapy on 04/20/2026. Orders were reviewed for presence of oxygen tubing change. Residents who receive oxygen therapy had a respiratory evaluation completed to assess for any adverse effects on 05/08/2026. Director of Nursing, or designee, will complete re-education to licensed nurses on the procedure and/ expectation on changing oxygen tubing starting on 05/09/2026. Director of Nursing, or designee, will conduct an audit to validate that oxygen tubing was changed and dated weekly for 5 weeks. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0695 SS = D	Continued from page 59 R16's care plan, printed 4/7/26, identified R16 was at risk for respiratory impairment related to chronic respiratory failure with hypoxia with an intervention to administer oxygen per MD orders. The care plan lacked any indication on how often the oxygen tubing should be changed or who would be responsible for changing the oxygen tubing. R16's Order Summary Report, dated 4/6/26, included the following orders: -"2L continuous oxygen via nasal cannula. Concentrator and cylinders with contents and regulators" with a start date of 2/18/26. The Order Summary Report lacked evidence of an order to change oxygen tubing. R16's medication and treatment administration record (MAR/TAR) for 4/1/26 to 4/14/26 included the following orders: -change oxygen tubing and humidifier bottles weekly. Date tubing in the afternoon every Thursday with a start date of 4/16/26. - Change oxygen tubing and humidifier bottles weekly. Date tubing as needed for visibly soiled or known contamination with a start date of 4/9/26. This order had a start date after survey entrance. -Oxygen at 2L/minute via nasal cannula every shift with a start date of 4/9/26 R16's Medication Administration Record and Treatment Administration Record (MAR/TAR) for March 2026 was reviewed and lacked any order for oxygen use or changing of oxygen tubing or oxygen supplies. R16's task log was reviewed and did not include any change of oxygen tubing. R16's progress notes from 3/1/26 through 4/7/26, made no mention of any oxygen tubing having been changed by staff. Observation and interview ON 4/7/26 at 8:29 a.m., of R16 identified he was observed sitting in his room in his wheelchair and reported he just got done eating. R16's oxygen tubing from the oxygen tank	F0695		05/19/2026

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F0695 SS = D	Continued from page 60 on the back of the chair was observed to be partially on the floor with no date on it. R16's oxygen tubing from the concentrator, which R16 was observed wearing, did not have a date on it. R16 stated the facility will change the tubing when it "doesn't fit" but couldn't explain what that meant or when the last time the tubing was changed. At 12:17 p.m., R16 was observed in the dining room for lunch. R16 was observed to have oxygen on via nasal cannula from his portable tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/8/26 at 9:55 a.m., R16 was observed to be leaving the facility. R16 was observed to have nasal cannula on and receiving oxygen from portable oxygen tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/9/26 at 2:53 p.m., R16 was observed propelling self in wheelchair in his room. R16 was observed receiving oxygen via nasal cannula from the portable tank located on the back of his wheelchair. The oxygen tubing, including the nasal cannula, from the oxygen concentrator was noted to be laying in a box on the floor. Neither oxygen tubing was dated or labeled. R16 stated he was unsure when the oxygen tubing was last changed. During an interview on 4/9/26 at 2:54 p.m., NA-C stated they are familiar with R16. Staff put oxygen on and off residents including R16. NA-C stated nursing assistants do not change oxygen tubing. NA-C observed R16's oxygen tubing and verified the set of oxygen tubing (from the oxygen tank or oxygen concentrator) was dated or labeled. NA-C stated they are unsure when it was last changed as it was not dated. During an interview on 4/10/26 at 12:54 p.m., nursing assistant (NA)-A stated they do not change the oxygen tubing for residents. Staff only turn the oxygen on and off and do not adjust any settings. NA-A thought it was the nurse's responsibility to change the tubing as nurse aides have never changed oxygen tubing. During an interview on 4/10/26 at 1:03 p.m., registered nurse (RN)-A stated oxygen tubing and supplies should be changed weekly to prevent infections and the nurses are responsible for this.	F0695		05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245319	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947

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F0695 SS = D	Continued from page 61 During an interview and document review on 4/10/26 at 1:04 p.m., RN-C stated oxygen tubing should be changed weekly, and nurses were responsible for ensuring that was completed. RN-C stated there would be an order to change the oxygen tubing. RN-C stated it was expected to date and label the oxygen tubing also. RN-C reviewed R16's medical record and verified the order to change R16's oxygen tubing was entered on 4/9/16 (after survey entrance) and there was no previous order. RN-C stated it was important to change oxygen tubing to prevent infection and prevent build up in the nasal cannula. During an interview on 4/10/26 at 3:21 p.m., the assistant director of nursing (ADON) stated the expectation was oxygen tubing was changed weekly for infection control purposes as not changing it can contribute to respiratory illnesses. The expectation would be for tubing and all supplies to be dated and labeled. The ADON verified there were no additional nursing or physician's orders prior to 4/9/26, to change R16's oxygen tubing or humidifier bottles and there should have been. On 4/14/26 at 9:53 a.m., the director of nursing (DON) stated the expectation would be oxygen tubing would be changed weekly and as needed to help decrease risk of infection as not changing it can put a resident more at risk for infection. This was to be documented on the MAR/TAR. Review of the current, undated Northwest Respiratory Services instruction sheet for oxygen use the facility used for direction for staff, identified staff were to change tubing every month and the nasal cannula every week.	F0695		05/19/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by:	F0698	R16 No longer resides at the facility. Current residents that receive dialysis have the potential to be affected. One other resident was identified. Identified resident's orders, care plan, and dialysis binder were audited for compliance on 05/08/2026. Dialysis communication binder initiated for residents receiving dialysis services on 05/08/2026. Executive Director, or designee, will re-educate IDT	05/19/2026

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F0698 SS = D	Continued from page 62 Based on interview and document review, the facility failed to implement or maintain an appropriate communication and collaboration system with an outside dialysis clinic to promote continuity of care and reduce the risk of complication (i.e., missed orders, insufficient preparation for treatment), ensure contact information for dialysis clinic was on the care plan and ensure orders were accurate for monitoring dialysis site for 1 of 1 residents (R16) reviewed for dialysis care and services. Findings include: R16's quarterly Minimum Data Set (MDS) assessment, dated 2/11/26, identified R16 had intact cognition with no hallucinations, delusions, or rejection of care. R16 required maximum amount of assistance or was dependent on staff for all Activities of Daily Living (ADLs) except showering (which R16 refused) and oral hygiene/eating which required staff set up. In addition, the MDS outline R16 received hemodialysis while a resident at the facility. R16's admission record indicated on 2/18/26, R16's primary diagnosis was end-stage renal disease. A secondary diagnosis, dated 11/21/25, included dependence on renal dialysis. During an interview on 4/6/26 at 4:08 p.m., R16 stated he goes to dialysis three days a week and had been on dialysis for about 8 months. R16 stated his dialysis access site was located on his right upper chest (a central venous catheter (CVC)) and showed the surveyor. R16's dialysis access site was covered with a bandage. R16's care plan, printed 4/7/26, indicated R16 had chronic kidney disease: end stage renal disease and dependence on renal dialysis with the following interventions: Check access site for lack of thrill/bruit, evidence of infection, swelling. or excessive bleeding per facility guidelines. Report abnormalities to MD. Confer with MD (physician) and/or dialysis treatment center regarding changes in medication. Coordinate dialysis care with dialysis treatment center.	F0698	Continued from page 62 and licensed nurses on ensuring that the dialysis information is listed in the care plan, communication process for dialysis clinic, and monitoring orders are in place starting on 05/09/2026. Executive Director, or designee, will conduct an audit for dialysis residents to ensure the appropriate information regarding the dialysis center is care planned, monitoring orders are in place, and communication process with the dialysis clinic is occurring appropriately weekly for 5 weeks. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0698 SS = D	Continued from page 63 Dialysis 3 times/week at [general clinic name] M/W/F. Sack Lunch to be sent with. Diet per MD orders. Initiated on 12/3/25 Fluid restriction per MD orders. Monitor vital signs as ordered. No blood pressure, IVS, or lab draws from right arm. Obtain labs as ordered and notify MD of results. R16's care plan lacked contact information for dialysis clinic including the phone number and address, the type of dialysis access site R16 had, appropriate monitoring for the type of dialysis access site, and evidence or direction on how or how often the facility would coordinate or collaborate with the offsite dialysis clinic. R16's Order Summary Report, dated 4/7/26, included the following orders: Dialysis – nurse must complete a post-dialysis UDA (assessment) in the afternoon every Monday, Wednesday, Friday with a start date of 11/24/25. Dialysis – nurse must complete a pre-dialysis UDA, print and send with resident to dialysis in the morning every Monday, Wednesday and Friday with a start date of 11/24/25. Do not obtain blood pressure or blood draws on the dialysis access site - right arm with a start date of 11/21/25. Enhanced barrier precautions related to dialysis every shift with a start date of 11/21/25. Fistula/AV Graft Site: Location right IJ (internal jugular vein) - Monitor site for presence of thrill, bruit, and signs and symptoms (s/s)x of infection. Notify MD for any abnormal findings. every shift with a start date of 11/24/25. Although this was initiated as an order, there was no indication R16 actually had a fistula or graft and no evidence the facility had clarified this order for accuracy. Hemo Dialysis (right tunneled catheter) (CVC) three times a week on Monday/Wednesday/Friday for dialysis at 11:00 a.m. with a return pick up time of 3:00 p.m. with a start date of 11/24/25.	F0698		05/19/2026

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F0698 SS = D	Continued from page 64 If the dialysis site is oozing, apply moderate pressure until bleeding subsides. (Do not use pressure dressings or bandages that will restrict blood flow. If bleeding continues, resident to be evaluated by physician for further intervention and dialysis center to be notified.) every shift as needed with a start date of 11/21/25. R16's Medication Administration Record and Treatment Administration Record (MAR/TAR) for March and April 2026 identified: Dialysis – nurse must complete post-dialysis UDA (assessment) in the afternoon every Monday, Wednesday, Friday with a start date of 11/24/25. All of which were documented as completed except 3/20/26 which was blank. Dialysis – nurse must complete pre-dialysis UDA, print and send with resident to dialysis in the morning every Monday, Wednesday and Friday with a start date of 11/24/25. All of which were documented as completed. Hemo Dialysis (right tunneled catheter) three times a week on Monday/Wednesday/Friday for dialysis at 11:00 a.m. with a return pick up time of 3:00 p.m. with a start date of 11/24/25. All of which were documented as completed. Remove dressing to fistula/graft site 4-6 hours post dialysis. Dialysis over at approximately 2-230pm most days, dressing should get removed at approximately 6/630-8pm in the evenings on M/W/F with a start date of 11/24/25 and end date of 4/6/26. Documentation indicated this was completed all days except 4/6/26. Although this was initiated on the TAR, there was no indication R16 actually had a fistula or graft and no evidence the facility had clarified this order for accuracy. The CVC site was not mentioned that staff should be only inspecting the dressing for signs or increased bleeding or infection surrounding the site with specific instructions to call the dialysis center (ESRD) if the dressing needed to be changed or removed, as it would be done weekly in the ESRD setting. If dialysis site is oozing, apply moderate pressure until bleeding subsides. (Do not use pressure dressings or bandages that will restrict blood flow. If bleeding continues, resident to be evaluated by physician for further intervention and dialysis center to be notified.) every shift as needed with a start	F0698		05/19/2026

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F0698 SS = D	Continued from page 65 date of 11/21/25. Fistula/AV Graft Site: Location right IJ - Monitor site for presence of thrill, bruit, and s/sx of infection. Notify MD for any abnormal findings every shift with a start date of 11/21/25 and end date of 4/10/26. Documentation indicated this was completed every day except for the following: 3/8/26 night shift: coded with a “9” (9 indicated per chart codes other/see progress note). 3/9/26 night shift: coded with a “9” 3/27/26 evening shift: coded with a “9” 3/27/26 night shift: coded with a “9” 3/28/26 day and evening shifts: coded with “2” (2 indicated per chart codes as refused) and night shift was blank. 3/29/26 day and evening shifts coded with “2”. 3/30/26 night shift coded with a “2”. 3/31/26 day shift: coded with a “2”. R16’s Post Dialysis Assessments reviewed from 3/1/26 to 4/6/26 and identified the following relevant information. On: 4/6/26: dialysis paperwork received (answered “yes”), weight was dated 3/25/26 at 3:27 p.m., and other vitals dated 4/6/26 at 7:17 a.m. No other pertinent information documented. 4/3/26: dialysis paperwork received, weight was dated 3/25/26 at 3:27 p.m. Thrill palpated, and bruit auscultated – both indicated “yes”. Pertinent information section – notified dialysis regarding sevelamer (medication used to control phosphorus levels for people on dialysis) and side effect. 4/1/26: dialysis paperwork received, weight was dated 3/25/26 at 3:27 p.m. No other pertinent information documented. 3/30/26: dialysis paperwork received, weight was dated 3/25/26 at 3:27 p.m. Thrill palpated, and bruit auscultated – both indicated “no”. No other pertinent information documented. 3/27/26: dialysis paperwork received, weight was dated 3/25/26 at 3:27 p.m. Temperature from	F0698		05/19/2026

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F0698 SS = D	Continued from page 66 3/27/26 at 9:28 a.m., and respirations from 3/27/26 at 9:28 a.m. Thrill palpated, and bruit auscultated – both indicated “yes”. Other pertinent information documented as “none.” 3/25/26: dialysis paperwork received. Temperature from 3/27/26 at 9:09 a.m., and respirations from 3/27/26 9:10 a.m. No other pertinent information documented. 3/23/26: dialysis paperwork received. Thrill palpated, and bruit auscultated – both indicated “yes”. No other pertinent information documented. 3/20/26: dialysis paperwork received. All vital signs including weight were dated 3/18/26. Thrill palpated, and bruit auscultated – both indicated “yes”. No other pertinent information documented. 3/18/26: dialysis paperwork received. Thrill palpated, and bruit auscultated – both indicated “yes”. No other pertinent information documented. 3/16/26: dialysis paperwork received. Weight was dated 3/14/26 at 2:09 p.m. Thrill palpated, and bruit auscultated – both indicated “no”. No other pertinent information documented. 3/13/26: dialysis paperwork received. Thrill palpated, and bruit auscultated – both indicated “yes”. Other pertinent information documented as “none.” 3/11/26: dialysis paperwork received. Weight dated 3/10/26 at 10:07 a.m. and all other vital dated 3/11/26 at 10:13 a.m. Thrill palpated, and bruit auscultated – both indicated “yes” with radio button answer. No other pertinent information documented. 3/9/26: dialysis paperwork received. Weight dated 3/3/26 at 5:56 p.m. and all other vitals dated 3/8/26 at 1:43 p.m. Thrill palpated, and bruit auscultated – both indicated “yes” with radio button answer. Other pertinent information documented as “none.” 3/6/26: dialysis paperwork received. Weight dated 3/3/26 at 5:56 p.m. and all other vitals dated 3/8/26 at 1:43 p.m. Thrill palpated, and bruit auscultated – both indicated “no” with radio button answer. The document was signed on 3/8/26. 3/5/26: dialysis paperwork received. Weight dated 3/3/26 at 5:56 p.m. and all other vital signs dated 3/4/36 at 4:55 p.m. Thrill palpated, and bruit auscultated – both indicated “yes” with radio button answer. No other pertinent information documented.	F0698		05/19/2026

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F0698 SS = D	Continued from page 67 3/4/26: dialysis paperwork received. Weight dated 3/3/26 at 5:56 p.m. Thrill palpated, and bruit auscultated – both indicated “yes” with radio button answer. No other pertinent information documented. 3/2/26: dialysis paperwork received. Weight dated 2/26/26 at 12:44 p.m. Thrill palpated, and bruit auscultated – both indicated “yes” with radio button answer. No other pertinent information documented. There was no evidence to support documentation had been received from the dialysis facility, nor was there evidence R16 had a fistula or graft, either old and non-functioning or new and developing where a bruit and thrill would need to be checked. R16’s progress notes, dated 3/1/26 to 4/6/26, were reviewed and identified staff were documenting some vitals and/or were using old data, however, the notes lacked the necessary observations of the current dialysis CVC for most notes. It was unknown if staff were referring to the CVC site as noted below: 3/2/26 at 6:05 p.m., R16 had dialysis treatment. No new orders received. “Bruit auscultated. Thrill was palpated. No bleeding noted at access site.” 3/4/26 at 4:55 p.m. “Bruit auscultated. Thrill was palpated. No bleeding noted at access site.” 3/4/26 at 3:27 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: -W [weight] 197.0 lbs on 3/3/26. His blood pressure (BP) was 98/58 millimeters of mercury (mm/hg) on 3/4/26. R16’s temperature (T) was 98.4 degrees Fahrenheit (F), pulse (P) 58 (beats per minute (BPM)) and his respirations (RR) were 16 (breaths per minute (bpm)). 3/5/26 at 1:32 p.m.: R16 had dialysis treatment. No new orders received. W 197.0 lbs on 3/3/26. His BP was 98/58 mm/hg and on 3/4/26 staff documented his previous T of 98.4 degrees F, P of 58 bpm and RR was16 bpm. “Bruit auscultated. Thrill was palpated. No bleeding noted at access site.” No new vitals had been obtained. 3/6/26 at 5:30 p.m.: R16 had dialysis treatment. No new orders received. “Bruit not auscultated. Thrill was not palpated. No bleeding noted at access site.” 3/9/26 at 5:53 p.m.: R16 had dialysis treatment. No new orders received. “Bruit auscultated. Thrill was palpated. No bleeding noted at access site.”	F0698		05/19/2026

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F0698 SS = D	Continued from page 68 3/11/26 at 6:32 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: W 205.8 lbs. on 3/10/26. His BP 107/57, T 97.9 degrees F, P 61 bpm, and RR was 16 bpm, were all used from vitals acquired earlier that day. “Bruit auscultated. Thrill was palpated. No bleeding noted at access site.” 3/13/26 at 5:58 p.m.: R16 had dialysis treatment. No new orders received. “Bruit auscultated. Thrill was palpated. No bleeding noted at access site.” 3/16/26 at 5:27 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: -W 205.6 lbs was obtained on 3/14/26. His BP 88/68 mm/hg, T was 98.2 F, P was 80 bpm, and RR was 16 and noted as taken on 3/16/26 at 9:42 a.m. “Bruit not auscultated. Thrill was not palpated. No bleeding noted at access site.” 3/18/26 at 5:52 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: -W 207.7 lbs on 3/18/26 at 4:10 p.m. on Wheelchair scale; BP 84/49 on 3/18/26 at 6:09 p.m. Sitting l/arm; T 98.8 on 3/18/26 at 6:09 p.m.: P 71 on 3/18/26 at 6:09 p.m. and R -16 on 3/18/26 at 6:09 a.m. “Bruit auscultated. Thrill was palpated. No bleeding noted at access site.” 3/20/26 at 9:03 a.m.: R16 had dialysis treatment. No new orders received. Vital Signs staff documented were noted to be from 3/18/26, 2 days previously and not upon return from dialysis. Staff continued to document “Bruit auscultated. Thrill was palpated. No bleeding noted at access site.” 3/21/26 at 1:19 p.m., staff mentioned an order note: “resident has a tunneled chest catheter and are unable to assess bruit/thrill with catheter. Only if resident had fistula/graft.”. There was no indication or mention staff had contacted the physician to discontinue the order to check for bruit and thrill on a non-existent fistula or graft. 3/22/26 at 6:36 a.m.: order note: “resident has a tunneled chest catheter. Unable to assess bruit/thrill as not a fistula or graft.” Again, there was no indication or mention staff had contacted the physician to discontinue the order to check for bruit and thrill on a non-existent fistula or graft. 3/23/26 at 4:06 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs had been appropriately taken. However, staff still documented “Bruit auscultated. Thrill palpated. No bleeding noted at access site.”	F0698		05/19/2026

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F0698 SS = D	Continued from page 69 3/25/26 at 3:36 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs had been appropriately taken. This time, staff documented “No bleeding noted at access site.”, however, it was unclear if staff had identified this was the CVC or a non-existent fistula or graft. 3/27/26 at 5:58 p.m.: R16 had dialysis treatment. No new orders received. Vital Signs: -W 212.9 lbs on 3/25/26 at 3:37 p.m. on Wheelchair scale; BP 98/67 on 3/27/26 at 5:59 p.m. Sitting l/arm; T 98.2 on 3/27/26 at 9:28 a.m.: P 65 on 3/27/26 at 6:00 p.m. and R -17 on 3/27/26 at 9:28 a.m. “Bruit auscultated. Thrill was palpated. No bleeding noted at access site.” 3/30/26 through 4/6/26, staff continued to document old vital sign data that had been taken sometimes from almost a week prior and were either documenting “Bruit not auscultated. Thrill was not palpated. No bleeding noted at access site.” or “No bleeding noted at access site”. R16’s medical record (paper chart and electronic medical record) was reviewed and lacked any summary report after dialysis to include vital signs, weights (pre-dialysis and post-dialysis), medications administered at dialysis, orders, or any overall concerns with R16 during dialysis. Furthermore, R16’s medical record lacked facility communication with dialysis center related to medication refusals in a timely manner, changes or declines in condition unrelated to dialysis. During an interview and document review on 4/10/26 at 1:04 p.m., registered nurse (RN)-C stated when a resident goes to dialysis, a pre and post assessment was to be completed. RN-C stated they are familiar with R16. The pre-assessment should be sent with the resident along with the order summary. If R16 doesn’t come back with paperwork such as vitals signs, medications administered, a run report, “they don’t’ do anything”. She doesn’t call the facility herself to follow up as she figured if they [dialysis] “didn’t send any paperwork then there weren’t any concerns”. RN-C assesses the site upon return for signs of infection. RN-C stated R16 had a right IJ (internal jugular) catheter for his dialysis catheter which would not have a thrill or bruit, so she doesn’t check for a thrill or bruit. RN-C verified the MAR/TAR indicated to check for thrill and bruit and shouldn’t.	F0698		05/19/2026

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LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947

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F0698 SS = D	Continued from page 70 During an interview on 4/10/26 at 1:04 p.m., RN-A stated a pre and post assessment was completed on R16 on dialysis days. RN-A stated if she ever called dialysis, it would be documented in a progress note. RN-A checks R16's catheter site for any signs of infection. RN-A stated she doesn't check for thrill or bruit as R16's dialysis site wouldn't have one due to the type of site. Staff often don't get anything back from dialysis. RN-A stated they send a notebook with R16 that dialysis can write in "if needed". RN-A unsure if this was documented in the resident's medical record. During an interview and document review on 4/10/26 at 3:23 p.m., assistant director of nursing (ADON) identified the facility has a legal pad of note paper that was sent back and forth for communication between the facility and dialysis center. The ADON was unsure if any of this was documented in R16's medical record. The dialysis center does not send any paperwork to the facility such as report runs which would include medications, weights before and after treatment, vital signs, etc. The ADON verified the contact information for the dialysis center was not on the care plan. During a follow up interview on 4/13/26 at 10:19 a.m., the ADON verified the contact number for dialysis was not listed on the care plan or on the banner in R16's medical record. She had now asked that any information in the notebook be entered into the medical record. ADON verified this would not necessarily include medical information obtained during dialysis. During an interview on 4/13/26 at 11:06 a.m., the dialysis registered nurse (RN)-D stated they are the dialysis care facility R16 received his treatment at. The facility sends paperwork and notebook with R16 "about 50% of the time". The facility had never requested any documentation from the dialysis center, therefore, they have never sent any to the facility. The dialysis center was not updated on medication changes from the facility. If R16 stated his medications were changed, the dialysis center has the capability to access what medications have been filled at pharmacies. RN-D verified they do not send the facility any weights, medications administered during dialysis, pressures on treatments, vitals, etc. During an interview on 4/14/26 at 9:50 a.m., director of nursing (DON) stated the expectation was the facility was communicating effectively with dialysis	F0698		05/19/2026

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F0698 SS = D	Continued from page 71 and receiving information needed to care for the residents. The DON verified the facility was not receiving information needed from the dialysis center such as vitals, weights, medications received, etc. and verified the facility had not been requesting this information. The DON also verified the contact information was not listed on R16's care plan nor on the banner of the electronic medical record and should be. A facility policy titled Hemodialysis, reviewed 9/10/23, identified the facility will ensure that the place of care for dialysis include "the dialysis facility name and phone number." Furthermore, the facility was to coordinate and collaborate with the dialysis facility to ensure: a. The residents' needs related to dialysis treatments are met; b. The provision of the dialysis treatments and care of the resident meets current standards of practice for the safe administration of the dialysis treatments. c. Documentation requirements are met to ensure that treatments are provided as ordered by the nephrologist, attending practitioner and dialysis team; and d. There was to be ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff.	F0698		05/19/2026
F0710 SS = D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician;	F0710	R5 was hospitalized 4/8/26 and registered nurse assessment completed upon re-admission on 4/9/26 which included a dehydration risk screener and a head-to-toe assessment. The Registered Dietician completed a Nutrition Assessment, which included estimated fluids needs. Consultant pharmacist, or designee, was consulted on 04/09/26 and medications were reviewed to ensure prior timing of medications in association with other medication interactions and indications (with food or fasting). Registered Dietician reviewed resident gastrostomy tube feeding and fluid orders on 4/9/26 and verified free fluid orders including water for medication pass. Director of Nursing consulted Primary Care physician on 04/10/26 with consultant pharmacist recommendations regarding timing of medications and Registered Dietician recommendations. Primary Care Physician contacted on 4/10/2026 regarding need for continued labs and at what frequency. Care plan updated 4/10/2026 to reflect observation for signs and symptoms of	05/19/2026

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F0710 SS = D	Continued from page 72 §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 primary care physician assistant (PA-A) had appropriately managed the care for 1 of 1 resident (R5) who experienced complications from tube feedings and medication administration through a gastrostomy tube (g-tube). Refer to F684 Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5 required hydration and nutrition via a feeding tube (g-tube). R5's current, undated care plan indicated the following: -urinary incontinence: report changes in skin integrity found during daily care -potential for pressure ulcer development: administer treatments as ordered, and monitor effectiveness follow facility policies/protocols for the prevention/treatment of skin breakdown monitor nutritional status monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth)	F0710	Continued from page 72 hyperparathyroidism, hypothyroidism, and at risk for fluid volume deficit and at risk for constipation. Care plan also updated to include both monitoring of intake and output, which would include estimation of amount of emesis, if/when emesis occurs. Current residents that receive medications and/or nutrition via gastrostomy tube feeding have the potential to be affected. No other residents were identified. Current residents that receive medications and/or nutrition via gastrostomy tube feeding have ability to be affected by this alleged deficient practice. Facility Policies on Medication administration, Enteral Medication Administration, Hydration, verifying placement of gastrostomy tube feeding, and change of condition policy were reviewed by Interdisciplinary Team on 4/9/2026. Facility Licensed Nurses will be re-educated by Director of Nursing or designee on identified policies and identified medication side effects and signs symptoms of hypothyroidism and hyperparathyroidism starting 4/9/2026 and will be completed prior to start of next scheduled shift. Facility licensed and non-licensed nursing staff were re-educated on positioning importance and elevating head of bed on residents receiving enteral medications and nutrition, starting 04/09/2026, occurring prior to start of next scheduled shift. Nursing assistants re-educated on completion of STOP and WATCH tool and notifying nurse for changes in condition, including subtle changes in condition. Licensed Nurses re-educated on how to respond to alerts, which includes assessment/data gathering and notification of provider when indicated. This eINTERACT/STOP and WATCH education will be completed by the Director of Nursing, or designee, and will be initiated on 4/10/2026 and will be completed prior to next scheduled shift. Staff were notified of need for re-education via a message on the electronic scheduling system. Knowledge check will be completed with Certified Nursing Assistants to validate understanding of STOP and WATCH/change in condition reporting process and a knowledge check will be completed with Licensed nurses regarding gastrostomy tube feeding and change in condition assessment/data gathering. Ad Hoc Quality Assurance and Performance Improvement meeting completed on 04/10/2026 with Interdisciplinary Team and Medical Director to review findings and plan.	05/19/2026

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F0710 SS = D	Continued from page 73 The need for a feeding tube/potential complications from that tube. R5 was to have no complications from the feeding tube. Staff were to administer formula and hydration and flushes per order. R5's care plan lacked identification of skin breakdown on R5's coccyx; further lacking goals and interventions for monitoring, treating, and documenting R5's actual skin breakdown. Additionally, R5's care plan lacked identification of R5's refusal of cares and treatments; further lacking goals and interventions to apply when R5 refused cares and treatments. R5's care plan lacked identification of R5's risk for fluid-volume imbalances; further lacking goals and interventions for monitoring, treating and documentation. R5's care plan lacked specific time requirements to elevate the head of the bed (HOB) to 30-45 degrees during and after tube feeding. Lastly, R5's care plan lacked specific symptoms, side effects, and monitoring of hypercalcemia, hypothyroidism, and hyperparathyroidism. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 milliliters (ml) water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician's orders, dated 1/26/26, included: -levothyroxine 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone 4 mg via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach.) -folic acid 1 milligrams (mg) via g-tube daily -apixaban 2.5 mg via g-tube twice daily -metoprolol tartrate 12.5 mg via g-tube twice daily -senna 8.6 mg via g-tube twice daily -cinacalcet 30 mg via g-tube twice daily	F0710	Continued from page 73 Audits will be implemented by Director of Nursing or designee starting 04/10/26 on gastrostomy tube feeding administration, medication administration via gastrostomy tube and positioning of resident with enteral nutrition or medications. Audits will be completed daily on varying shifts x 7 days. Audits will continue no less than 3 times per week for 4 weeks or until substantial compliance is maintained. Director of Nursing or Designee will review facility charting daily to identify resident change in condition, to ensure proper documentation of assessment/evaluation and timely provider notification. These audits will be completed daily x7 days, then with morning clinical 5 days per week for 8 more weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0710 SS = D	Continued from page 74 -omeprazole- oral suspension 10ml daily -ascorbic acid 500 mg via g-tube daily R5's physician's orders lacked monitoring of electrolytes, monitoring accurate intake and output, managing fluid balance in relation to tube feedings and free water, medication interaction and interventions to prevent adverse effects, a process to monitor ongoing symptoms of nausea, vomiting, abdominal pain, and when staff should alert the provider when R5 refuses medications or treatments. During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 has a complicated gastrointestinal (GI) tract. R5 has hyperparathyroidism and this is the source of her hypercalcemia. R5 is no longer a surgical candidate to have her parathyroid removed, symptom management has been the primary direction of care. PA-A stated electrolyte imbalances will be an ongoing concern for R5. PA-A stated she didn't have plans to order follow up bloodwork to monitor electrolytes because she thought the consulting services (Nephrology, Endocrinology) would be monitoring them. PA-A stated she was not sure what the electrolyte monitoring schedule would be. PA-A stated she is unsure how often the nutrition team is working with R5 or how involved they are with her care. She is unsure if the nutrition team was monitoring specifically intake and output. During a follow up interview on 4/8/26 at 2:39 p.m., PA-A stated she relied on the pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. PA-A had not directly communicated to the facility consultant pharmacist about R5's medication needs in relation to her tube feedings. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. PA-B stated she expected the facility providers to manage the calcium levels after discharge as she was a member of the hospital consulting service and infrequently sees R5. PA-B stated medication interactions should be managed by the facility provider and pharmacist; additionally, medication administration times should be assessed by the facility provider and pharmacist.	F0710		05/19/2026

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F0710 SS = D	Continued from page 75 During an interview on 04/09/2026 at 11:54 AM, PA-C stated frequently monitoring of calcium should be complete weekly until R5's calcium levels are stable, then monthly, then every six months. R5 has been on cinacalcet to manage her high calcium levels; she is on a consistent dose, but ongoing monitoring should still be weekly to bi-weekly. PA-C stated the facility providers are responsible for monitoring electrolytes, she would not be requesting electrolyte levels unless she saw R5 again as outpatient or in the hospital. On 4/14/26 at 10:22 a.m., a call was placed to the facility Medical Director; no return call received. A facility policy titled Medical Director Responsibilities dated 4/22/25, the medical director responsibilities included addressing issues related to coordination of medical care an implementation of resident care policies, ensuring the appropriateness and quality of medical care and medically related care, discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care.	F0710		05/19/2026
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. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate,	F0756	R15 continues to reside at the facility. Orthostatic BP was obtained on 04/20/2026. No adverse effects were noted. R5 was hospitalized 4/8/26 and registered nurse assessment completed upon re-admission on 4/9/26 which included a dehydration risk screener and a head-to-toe assessment. The Registered Dietician completed a Nutrition Assessment, which included estimated fluids needs. Consultant pharmacist or designee was consulted on 04/09/26 and medications were reviewed to ensure prior timing of medications in association with other medication interactions and indications (with food or fasting). Registered Dietician reviewed resident tube feeding and fluid orders on 4/9/26 and verified free fluid orders including water for medication pass. Director of Nursing consulted Primary Care physician on 04/10/26 with consultant pharmacist recommendations regarding timing of medications and Registered Dietician recommendations. Primary Care Physician contacted on 4/10/2026 regarding need for continued labs and at what frequency. Care plan updated 4/10/2026 to reflect observation for signs and symptoms of hyperparathyroidism, hypothyroidism, and at risk for fluid volume deficit and at risk for constipation. Care plan also updated	05/19/2026

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F0756 SS = D	Continued from page 76 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 record review, the facility failed to identify irregularities in monthly drug regimen monitoring review for 1 of 5 residents (R15) reviewed for unnecessary medications who received antipsychotic medications. Additionally, the facility failed to identify potential medication side effects for 1 of 1 resident (R5) reviewed for medication administration. Findings include: R15's quarterly Minimum Data Set (MDS), dated 2/12/26, identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing)	F0756	Continued from page 76 to include both monitoring of intake and output, which would include estimation of amount of emesis, if/when emesis occurs. Current residents that receive medications and/or nutrition via tube feeding have the potential to be affected. No other residents were identified. Current residents requiring orthostatic BP monitoring related to medications have the potential to be affected. An audit was conducted by the Director of Nursing, or designee, and the pharmacy consultant to identify medications requiring orthostatic BP monitoring. Orders and care plans were reviewed and updated starting on 05/06/2026. Current residents that receive medications and/or nutrition via tube feeding have ability to be affected by this alleged deficient practice. Facility Policies on Medication administration, Enteral Medication Administration, Hydration, verifying placement of tube feeding, and change of condition policy were reviewed by Interdisciplinary Team on 4/9/2026. Director of Nursing, or designee, re-educated licensed nurses regarding medication side effect monitoring of orthostatic BP orders starting on 05/09/2026. Facility Licensed Nurses will be re-educated by Director of Nursing or designee on identified policies and identified medication side effects and signs symptoms of hypothyroidism and hyperparathyroidism starting 4/9/2026 and will be completed prior to start of next scheduled shift. Facility licensed and non-licensed nursing staff were re-educated on positioning importance and elevating head of bed on residents receiving enteral medications and nutrition, starting 04/09/2026, occurring prior to start of next scheduled shift. Nursing assistants re-educated on completion of STOP and WATCH tool and notifying nurse for changes in condition, including subtle changes in condition. Licensed Nurses re-educated on how to respond to alerts, which includes assessment/data gathering and notification of provider when indicated. This eINTERACT/STOP and WATCH education will be completed by the Director of Nursing, or designee, and will be initiated on 4/10/2026 and will be completed prior to next scheduled shift. Staff were notified of need for re-education via a message on the electronic scheduling system. Knowledge check will be completed with Certified Nursing Assistants to validate understanding of STOP and WATCH/change in condition reporting process and a knowledge check will be completed with Licensed nurses regarding tube feeding and change in condition	05/19/2026

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F0756 SS = D	Continued from page 77 During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April. During a record review of R15's pharmacy review and recommendations, the pharmacist failed to address the lack of blood pressure monitoring being completed by staff in the course of their monthly reviews on 11/4/25, 2/5/26, and 4/7/26 for the above-mentioned months. During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her orthostatic blood pressure completed monthly. Additionally, if orthostatic blood pressures were ordered, it was her expectation they should get completed monthly. When the consultant pharmacist performed the monthly review of medications, they were to identify when orthostatic blood pressures weren't being completed and should put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible. During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. Additionally, she would expect nursing to complete the orders as written and document why they weren't done. Lastly, since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures.	F0756	Continued from page 77 assessment/data gathering. Ad Hoc Quality Assurance and Performance Improvement meeting completed on 04/10/2026 with Interdisciplinary Team and Medical Director to review findings and plan. Director of Nursing, or designee, will conduct an audit to ensure orthostatic blood pressures were completed as applicable. This audit will occur 3 times per week for 5 weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations. Audits will be implemented by Director of Nursing or designee starting 04/10/26 on tube feeding administration, medication administration via gastrostomy tube and positioning of resident with enteral nutrition or medications. Audits will be completed daily on varying shifts x 7 days. Audits will continue no less than 3 times per week for 4 weeks or until substantial compliance is maintained. Director of Nursing or Designee will review facility charting daily to identify resident change in condition, to ensure proper documentation of assessment/evaluation and timely provider notification. These audits will be completed daily x7 days, then with morning clinical 5 days per week for 8 more weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947**

(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
F0756 SS = D	Continued from page 78 R5 According to the American Society for Parenteral and Enteral Nutrition article, “Medication via Enteral Feeding Tubes: A Clinician's Guide”, located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities. R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5’s care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5’s care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. R5’s phyician’s order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass.	F0756		05/19/2026

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F0756 SS = D	Continued from page 79 R5's physician's orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. Additionally, she relies on the consultant pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. Additionally, medication interactions should be managed by the facility provider and pharmacist. Further, medication administration times should be assessed by the facility provider and pharmacist. Medications given with other medications or around tube feedings can have side effects for R5 that	F0756		05/19/2026

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F0756 SS = D	Continued from page 80 include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. The medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's	F0756		05/19/2026

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F0756 SS = D	Continued from page 81 specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications.	F0756		05/19/2026
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%) resulting in an 8.57 % medication error rate, identified during 3 of 25 medication administration observations. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5's physician's orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach.	F0759	R5 continues to reside at the facility. A registered nurse assessment was completed upon re-admission on 4/9/26. Consultant pharmacist/designee was consulted on 04/09/26 and medications reviewed to ensure prior timing of medications in association with other medication interactions and indications (with food or fasting). Registered Dietician, or designee, reviewed gastrostomy tube feeding and fluid orders on 4/9/26 and verified free fluid orders including water for medication pass. Consulted Primary Care physician 04/10/26 with consultant pharmacist recommendations regarding timing of medications and any Registered Dietician recommendations. Current residents that receive medications and/or nutrition via gastrostomy tube feeding have the potential to be affected. No other residents were identified. Director of Nursing, or designee, will re-educate facility Licensed Nurses on the facility policies on Medication administration and Enteral Medication Administration starting on 04/09/2026. Starting on 04/10/2026, Director of Nursing, or designee, will conduct random audits on gastrostomy tube feeding administration and medication administration via gastrostomy tube 5 times weekly for 5 weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0759 SS = D	Continued from page 82 -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily (prepped 15ml) -ascorbic acid (vitamin C) 500 mg via g-tube daily During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 15 ml instead of the ordered 10 ml. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she had not had g-tube education for "some time." RN-A stated the facility had not had a resident that required tube feedings with medication administration or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. RN-A stated she should have read the pharmacy alerts on the medications. She acknowledged she should have verified the liquid dose a 2nd time to make sure she had the right amount of the liquid. During an interview on 4/9/26 at 11:22 a.m., assistant director of nursing (ADON) stated the	F0759		05/19/2026

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F0759 SS = D	Continued from page 83 process to administer medication includes verifying the right resident, right dose, right route, right drug, and right time. She stated if the individual medications have a pharmacy alert such as take with food, don't give with certain medications; it is an expectation you follow those drug administration guidelines. She stated if you don't follow those recommendations, medications could be less effective, more effective, cause side effects, or not be effective at all. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. During an interview on 4/14/26 at 9:35 a.m., the administrator stated the medication regulation is facilities should have less than a 5% error rate. The facility's medication error rate of 8.57% is above the acceptable regulation standard. Staff should be confirming the five medication rights (right resident, right dose, right route, right drug, and right time) and it is an expectation staff should follow the pharmacy directions on each medication package. If staff can't follow the direction of medication from pharmacy, they are expected to reach out to pharmacy or the resident's provider to get order administration clarification. She stated the importance of performing medication administration accurately is to maintain patient safety. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications.	F0759		05/19/2026
F0838 SS = D	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations	F0838	R5 was hospitalized 4/8/26 and registered nurse assessment completed upon re-admission on 4/9/26 which included a dehydration risk screener and a head-to-toe assessment. The Registered Dietician completed a Nutrition Assessment, which included estimated fluids needs. Consultant pharmacist or designee was consulted on 04/09/26 and medications were reviewed to ensure prior timing of medications in association with other medication interactions and indications (with food or	05/19/2026

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F0838 SS = D	Continued from page 84 (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and	F0838	Continued from page 84 fasting). Registered Dietician reviewed resident gastrostomy tube feeding and fluid orders on 4/9/26 and verified free fluid orders including water for medication pass. Director of Nursing consulted Primary Care physician on 04/10/26 with consultant pharmacist recommendations regarding timing of medications and Registered Dietician recommendations. Primary Care Physician contacted on 4/10/2026 regarding need for continued labs and at what frequency. Care plan updated 4/10/2026 to reflect observation for signs and symptoms of hyperparathyroidism, hypothyroidism, and at risk for fluid volume deficit and at risk for constipation. Care plan also updated to include both monitoring of intake and output, which would include estimation of amount of emesis, if/when emesis occurs. Current residents that receive medications and/or nutrition via tube feeding have the potential to be affected. No other residents were identified. Current residents that receive medications and/or nutrition via tube feeding have ability to be affected by this alleged deficient practice. Facility Policies on Medication administration, Enteral Medication Administration, Hydration, verifying placement of tube feeding, and change of condition policy were reviewed by Interdisciplinary Team on 4/9/2026. Facility Licensed Nurses will be re-educated by Director of Nursing, or designee, on identified policies and identified medication side effects and signs symptoms of hypothyroidism and hyperparathyroidism starting 4/9/2026 and will be completed prior to start of next scheduled shift. Facility licensed and non-licensed nursing staff were re-educated on positioning importance and elevating head of bed on residents receiving enteral medications and nutrition, starting 04/09/2026, occurring prior to start of next scheduled shift. Nursing assistants re-educated on completion of STOP and WATCH tool and notifying nurse for changes in condition, including subtle changes in condition. Licensed Nurses re-educated on how to respond to alerts, which includes assessment/data gathering and notification of provider when indicated. This eINTERACT/STOP and WATCH education will be completed by the Director of Nursing, or designee, and will be initiated on 4/10/2026 and will be completed prior to next scheduled shift. Staff were notified of need for re-education via a message on the electronic scheduling system. Knowledge check will be completed with Certified Nursing Assistants to validate understanding of STOP and WATCH/change	05/19/2026

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F0838 SS = D	Continued from page 85 volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.	F0838	Continued from page 85 in condition reporting process and a knowledge check will be completed with Licensed nurses regarding tube feeding and change in condition assessment/data gathering. Ad Hoc Quality Assurance and Performance Improvement meeting completed on 04/10/2026 with Interdisciplinary Team and Medical Director to review findings and plan. Audits will be implemented by Director of Nursing or designee starting 04/10/26 on tube feeding administration, medication administration via gastrostomy tube and positioning of resident with enteral nutrition or medications. Audits will be completed daily on varying shifts x 7 days. Audits will continue no less than 3 times per week for 4 weeks or until substantial compliance is maintained. Director of Nursing or Designee will review facility charting daily to identify resident change in condition, to ensure proper documentation of assessment/evaluation and timely provider notification. These audits will be completed daily x7 days, then with morning clinical 5 days per week for 8 more weeks or until substantial compliance is maintained. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0838 SS = D	Continued from page 86 §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement their facility assessment to identify 1 of 1 resident (R5) who required specialty care and services and the facility failed to train and perform skill competencies as outlined in the facility assessment. Refer to F684 Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5 was admitted to the facility on 1/16/26 with an admission diagnosis of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms).	F0838		05/19/2026

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F0838 SS = D	Continued from page 87 A review of R5's medical record identified the following hospitalizations/emergency room visits identified on: 2/12/26: R5 was sent to the hospital after a fall with decrease cognition and returned to the facility on 2/22/26; the primary diagnosis was hypercalcemia. R'5 Power of Attorney (POA) was activated during this hospital visit and thereafter due to ongoing intermittent confusion. 3/6/26: R5 was sent to the hospital as a result of increased nausea and vomiting and returned to the facility on 3/10/26; the primary diagnosis was hypercalcemia. 4/6/26: R5 was sent to the emergency room as a result of increased abdominal pain and returned to the facility on 4/6/26; the primary diagnosis was pleural effusion (collection of fluid around your lungs.) 4/8/26: R5 was sent to the hospital and returned to the facility on 4/9/26; the primary diagnosis was right-sided pneumonia (acute inflammation of the lung caused by an infection, commonly caused by aspiration.). R5's care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. Additionally, the care plan lacked assessment and interventions for the risk of fluid volume deficits. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass.	F0838		05/19/2026

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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
F0838 SS = D	Continued from page 88 R5's physician orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily According to the American Society for Parenteral and Enteral Nutrition article, "Medication via Enteral Feeding Tubes: A Clinician's Guide", located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities.	F0838		05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245319	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/14/2026

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F0838 SS = D	Continued from page 89 During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 20ml instead of the ordered 15ml. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. At time of administration, RN-A failed to ensure the head of the bed was 30-45 degrees, with the bed remaining at approximately 10 degrees and R5 slouched down in the bed. RN-A stated R5 received a 30ml water flush before medication administration, 30ml water flush in between each medication, and a 150ml water flush at the end of the medication administration. During medication administration, RN-A diluted each medication with approximately 2ml of water, which failed to dilute the medication enough to allow it to pass through the g-tube. When RN-A put the medication into the barrel of syringe attached to the g-tube, the medication was not diluted enough to flow, RN-A then begun adding additional unmeasured amounts of water and continued to add until the medication would flow; 2 medications required pressure from the syringe plunger to flow through the g-tube. During medication administration process, R5 stated she was having increased nausea and abdominal pain. RN-A failed to recognize R5 was still not at the correct position. During administration RN-A failed to flush the g-tube between medications levothyroxine and metoprolol. RN-A was unsure what effect this could have on R5. After administration was completed, RN-A failed to set the head of the bed up to 30-45 degrees; bed remained at approximately 10 degrees with R5 slouched down in bed.	F0838		05/19/2026

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F0838 SS = D	Continued from page 90 During an interview on 4/8/26 at 10:36 a.m., RN-A stated she had not had g-tube education for “some time.” RN-A stated the facility had not had a resident that required tube feedings or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. During an interview on 4/9/26 at 11:22 a.m., licensed practical nurse (LPN)-B stated R5 had frequent nausea and vomiting. LPN-B stated they only track R5's bowel movements for output. LPN-B stated R5's emesis are not documented in R5’s medical record. LPN-B described the process of administering medications via g-tube which did not include elevating head of bed during or after administration of medications or enteral feedings. During an interview on 4/7/26 at 3:15 p.m., vice president of success (VPS)-A stated nurses wereeducated about g-tubes annually and for regular competencies. VPS-A stated nurses can receive g-tube education sporadically; they didn’t believe nursing staff were educated about the needs of R5 prior to her arrival. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated she believed the facility provided education to staff about g-tubes but couldn’t find the specific education. DON stated she would expect education to be given for g-tubes, tube feeding administration, medication administration, g-tube complications, and g-tube side effects or symptoms. DON stated the facility had not cared for a resident with a g-tube in about a year. DON stated, generally g-tube education is annually, she did not provide g-tube education to staff about this R5 and her specific needs. DON stated it would have been beneficial to have educated staff specifically about R5 so staff could be prepared for any complications. A Facility Assessment dated 7/11/25, the facility leadership uses the facility assessment for decision-making purposes including when to consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. Further, training and skills unique to resident population: our nurses are trained in enteral feedings; our facility not only	F0838		05/19/2026

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F0838 SS = D	Continued from page 91 conducts a skill assessment during floor orientation of nurses and nursing assistants but also conducts monthly competencies of various skills to ensure that annual training occurs to keep skills honed. Relias training and skill competencies are scheduled monthly. Facility staff are specifically trained with skills unique to resident population, such as tube feedings.	F0838		05/19/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help 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	F0880	R5 and R20 continue to reside at the facility. Nursing assessments were completed for R5 and R20 with no adverse effects noted. Current residents who are on Enhanced Barrier Precautions have the potential to be affected. Director of Nursing, or designee, conducted an audit of current residents to validate Enhanced Barrier Precautions interventions are in place if applicable on 05/08/2026. Director of Nursing, or designee, conducted re-education to facility staff on Enhanced Barrier Precautions starting on 05/09/2026. Director of Nursing, or designee, will conduct an audit for the appropriate use of PPE for residents on Enhanced Barrier Precautions 3 times weekly for 5 weeks. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0880 SS = D	Continued from page 92 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 2 of 2 residents (R5, R20) reviewed for transmission-based precautions. Findings include: R20’s quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition with no hallucination, delusions or other behavioral symptoms noted and was dependent on staff for activities of daily living (ADLs) except eating which R20 required maximal staff assistance. The MDS indicated R20 had an indwelling catheter. During an observation on 4/8/26 at approximately	F0880		05/19/2026

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F0880 SS = D	Continued from page 93 7:20 a.m., RN-A was observed to enter R20's room and performed hand hygiene prior to entering room with hand sanitizer. A plastic bin was observed outside the doorway and inside the bin were personal protective gowns and gloves. Hand sanitizer was available from a dispenser on the wall. On the door, was a single page sign hung indicating "Enhanced Barrier Precautions." Signage was orange in color, CDC (Center for Disease Control and Prevention) emblem on the bottom right corner, two stop signs on the upper right and upper left corners of the page and indicated: " Everyone must: Clean their hands, including before entering and when leaving the room," and "Providers and Staff must also: 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, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wounds Care: any skin opening requiring a dressing." R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A. RN-A performed a respiratory assessment on R20 which included a pulse oximeter reading, and breath sounds. RN-A held R20's inhaler while she did the treatment, then had R20 rinse her mouth and spit in a cup that RN-A was holding. RN-A prepared R20's nebulizer and placed the mask on R20's face. RN-A placed R20's call light pad on her lap and instructed her to turn her call light on when the treatment was completed. RN-A exited R20's room and used hand sanitizer. R20's April medication/treatment administration report (MAR), printed 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR. -Respiratory assessment prior to nebulizer treatment. Document Respirations, Pulse, O2 Sat,	F0880		05/19/2026

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F0880 SS = D	Continued from page 94 and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being documented with code. -Respiratory assessment after nebulizer treatment. Document Respirations, Pulse, O2 Sat, and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being documented with code. -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26. -Catheter care every morning and at bedtime for urinary retention with a start date of 1/20/26. R20's order summary report, dated 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. -Catheter Care every morning and at bedtime for urinary retention starting 1/20/26. -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26.	F0880		05/19/2026

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F0880 SS = D	Continued from page 95 R20's care plan, initiated on 1/20/26, indicated R20 had indwelling urinary catheter. Interventions were all updated on 3/8/26 and included: administer medications per MD order; catheter care; catheter collection bag place din dignity bag holder on b ed/wheelchair; change urinary collection bag as needed; maintain drainage bag below bladder level; report any changes in amount and color, or odor of urine; report to MD signs of UTI (urinary tract infection) such as blood, cloudy urine, fever, increased restlessness, lethargy, complaints of pain or burning. The care plan lacked identification R20 was on enhanced barrier precautions. During an interview on 4/8/26 at 11:50 a.m., RN-A verified they did administer R20's medications 4/8/26 which included a nebulizer, inhaler, oral medications and performed a respiratory assessment. RN-A stated they did not wear a gown and stated they did not touch R20's catheter which was the reason R20 was on EBP. RN-A stated they should have worn a gown since they did a respiratory assessment with the resident and the EBP sign on the door. R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she should have been wearing the appropriate personal protective equipment (PPE) when providing care or administering medications to R5. She stated R5 required enhanced barrier precautions (EBP) and additional PPE (gown and gloves) were needed due to her g-tube. She stated the appropriate PPE is important to prevent the spread of infection from residents to residents.	F0880		05/19/2026

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F0880 SS = D	Continued from page 96 During an interview on 4/14/26 at 9:55 a.m., director of nursing (DON) stated the expectation would be that if a resident on enhanced barrier precautions, the proper PPE would be worn as this helps stop the transmission of infections. DON stated she would expect proper PPE to be worn for a resident on EBP while a respiratory assessment is being performed along with a setting up and administering a nebulizer treatment. A facility policy titled Enhanced Barrier Precautions, dated 8/8/24, identified the facility will implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms and an order for enhanced barrier precautions will be initiated for residents with any of the following: “Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, peripherally inserted central catheters (PICCs), hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MORO. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions.”	F0880		05/19/2026
F0941 SS = D	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure staff completed mandatory communication training for 2 of 10 staff (nursing assistant (NA)-A, licensed practical nurse (LPN)-B) reviewed for training requirements. This had the potential to affect all 34 residents residing in the facility. Findings include: The facility assessment dated 7/11/25, indicated the facility had developed a training program that included an orientation process and ongoing training	F0941	Specifically affected residents were not identified during survey. Current residents have the potential to be affected. The facility training schedule was reviewed by the interdisciplinary team and adjusted appropriately on 04/21/2026. An audit was conducted by the Executive Director, or designee, for current staff to validate completion of communication training on 05/08/2026. Vice President of Success educated the Executive Director and Director of Nursing on the requirement for Communication training and the validation of completion process on 05/07/2026. Executive Director, or designee, will provide re-education to current facility staff on communication starting on 05/09/2026. Executive Director, or designee, to conduct an audit of Communication training weekly for 5 weeks to ensure that facility employees’ Communication	05/19/2026

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F0941 SS = D	Continued from page 97 for all new and existing staff to ensure the programs meet the regulatory requirements. The assessment indicated all staff were to receive training in communicating effectively. During an interview on 4/13/26 at 10:59 a.m., administrator stated she was responsible for overseeing and ensuring all staff completed the required training. During a follow up interview on 4/14/26 at 11:06 a.m., the administrator was informed the education on effective communication was not found the personal files she had provided for LPN-B and NA-A. Administrator verified the trainings had not been completed at this time for either LPN-B or NA-A. A facility policy regarding required staff training was requested and not received.	F0941	Continued from page 97 training has been completed. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026
F0944 SS = D	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure staff completed mandatory quality assurance and performance improvement training for 6 of 10 staff (registered nurse (RN)-A, licensed practical nurse (LPN)-B, nursing assistant (NA)-A, NA-D, NA-E, and NA-F) reviewed for training requirements. This had the potential to affect all 34 residents residing in the facility. Findings include: The facility assessment dated 7/11/25, indicated the facility had developed a training program that included an orientation process and ongoing training for all new and existing staff to ensure the programs meet the regulatory requirements. The assessment indicated all staff were to receive training in quality assurance and performance improvement (QAPI).	F0944	Specifically affected residents were not identified during survey. Current residents have the potential to be affected. The facility training schedule was reviewed by the interdisciplinary team and adjusted appropriately on 04/21/2026. An audit was conducted by the Executive Director/designee for current staff to validate completion of communication training on 05/08/2026. Vice President of Success educated the Executive Director and Director of Nursing on the requirement for Quality Assurance and Performance Improvement training and the validation of completion process on 05/07/2026. Executive Director, or designee, will provide re-education for current facility staff on communication starting on 05/09/2026. Executive Director, or designee, to conduct an audit of Quality Assurance and Performance Improvement training weekly for 5 weeks to ensure that facility employees' Quality Assurance and Performance Improvement training has been completed. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

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F0944 SS = D	Continued from page 98 During an interview on 4/13/26 at 10:59 a.m., administrator stated she was responsible for overseeing and ensuring all staff completed the required training. During a follow up interview on 4/14/26 at 11:06 a.m., the administrator was informed the education on QAPI was no found the personal files she had provided for LPN-B and RN-A. Administrator verified the trainings had not been completed at this time for either LPN-B or RN-A. Administrator reviewed trainings upon orientation and verified QAPI trainings are not completed at orientation. Administrator stated they are completed through the online training program at this time. Furthermore, training was not completed at this time for NA-A, NA-D, NA-E or NA-F upon further review. A facility policy regarding required staff training was requested and not received.	F0944		05/19/2026
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying	F0577	Specifically affected residents were not identified during survey. Current residents and visitors have the potential to be affected. No adverse effects were noted. The previous 3-year life safety survey results were added to the survey binder on 05/06/2026. Vice President of Success provided the Executive Director with re-education on the procedure for having survey results available in the survey binder on 05/06/2026. Vice President of Success, or designee, will conduct an audit of the survey binder 1 time per month for 3 months to ensure survey results are available. The results of the audit will be brought to Quality Assurance Performance Improvement for review and recommendations.	05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245319	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA CRESCENT HEALTH SERVICES	101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947

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F0577 SS = C	Continued from page 99 information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent survey results were posted in a prominent location and readily accessible to person wishing to review such information. This had potential to affect all 34 residents residing in the nursing home or any visitors who wanted to review this information. Findings include: The CMS Provider History Report, dated 4/3/26, identified the completed recertification for the previous three years, with the most recently completed recertification survey having exited on 2/6/25. On 4/8/26 at 1:34 p.m., an informal resident council meeting was held with R10, R15 and R30. The residents were asked, as part of the meeting, if the most recent survey results were readily posted within the facility for them to review at leisure. However, none of the residents voiced they knew the location or these results, nor had the results been discussed with them during the resident council meetings. During an interview and tour on 4/10/26 at 8:22 a.m., administrator stated she was responsible for the survey results binder. The survey binder was located near the main entrance at waist level and was labeled State Survey Results. Administrator reviewed the binder and verified the most recent survey exited on 2/6/25 did not include the plan of correction nor the life safety code component. The binder did not contain any of the life safety code surveys for the past 3 years. The survey results binder did not include any signage that additional survey results were available upon request. The bulletin board above where the survey binder was located did not include any signage of additional survey results available upon request. Administrator stated she didn't realize the life safety code surveys needed to be included or the plan of corrections. Administrator stated she would get this updated. A facility policy titled Availability of Survey Results, reviewed 6/16/22, indicated "the facility will maintain reports of any survey, certifications, and complaint	F0577		05/19/2026

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F0577 SS = C	Continued from page 100 investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility.”	F0577		05/19/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 26, 2026

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

Re: Reinspection Results
Event ID: 1F3549-H2

Dear Administrator:

On June 4, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 14, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 26, 2026

Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: CCN: 245319
Cycle Start Date: April 14, 2026

Dear Administrator:

On May 4, 2026, we notified you a remedy was imposed.

On June 4, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 19, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 19, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 4, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 14, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst

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

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/6/26 through 4/14/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed:	20000		05/19/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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20000	Continued from page 1 H53195940C (255111746 and 2739638) and H53191098C (247735426). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		05/19/2026
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member	20265	Corrected.	05/19/2026

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20265	Continued from page 2 of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to notify 1 of 1 resident's (R5) representative (also the Power of Attorney) when R5 was sent to the emergency department after a fall, and for repeated refusals of care upon her return to the facility. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional	20265		05/19/2026

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20265	Continued from page 3 urinary incontinence but was always continent of bowel. During a record review, R5's dismissal summary from the 2/12/26 hospitalization; the hospital physician stated, "R5 is unable to receive and evaluate information effectively and communicate decisions necessary to manager her health. I recommend that the provisions contained in her Power of Attorney for Health Care be activated". During a record review, R5's POA was activated at the facility upon return from the 2/12/26 hospitalization. R5's care plan failed to address R5's refusals of care; additionally, the care plan failed to provide direction, so staff know when to notify provider and POA about refusals of care and medications. R5's orders failed to address R5's refusals of care; additionally, the orders lacked direction, so staff knew when to notify the medical providers and POA about refusals of care and medications. During record review, R5 refused medications or treatment on the following dates after the POA was activated: -3/6/26: refusal to have blood drawn, no POA notification -4/6/26: refused weight measurements, no POA notification -4/7/26 at 5:16 a.m.: refused constipation medication, no POA notification -4/7/26 at 12:22 p.m.: refused constipation medication, no POA notification -4/7/26 at 8:58 p.m.: R5 stated her pain was worse, no POA notification -4/8/26 at 4:58 a.m.: R5 stated her pain had gotten worse, refused all bowel medications, no POA notifications During record review, there was no documentation R5's POA had been notified prior to leaving the	20265		05/19/2026

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20265	Continued from page 4 facility to go to the Emergency Room (ER) on 2/12/26 after suffering a fall at the facility. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's POA was activated when she returned from the hospital on 2/22/26. DON stated the POA was activated when R5 was in the hospital because R5 had increasing periods of confusion and lack of understanding about her medical status. DON confirmed R5 has been intermittently refusing cares or treatments since the beginning of February. DON stated the facility doesn't notify the POA of refusals, probably should if the resident doesn't understand her condition or how the meds work. DON stated it is important to notify the POA about refusal of cares and treatments, so the POA knows the treatments R5 is or isn't receiving. Attempted phone call to speak with R5 POA made on 4/7/26 at 10:45 a.m. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated she was aware R5 had intermittently been refusing medications. PA-A stated she would expect to be notified of ongoing refusals. PA-A stated R5 did not have an order to notify facility providers or POA of refusals of cares or treatments. PA-A stated notification to the POA is important, so the POA understands what treatments R5 isn't getting and why. Additionally, the POA may have some influence with R5 and encourage R5 to accept the cares and treatments. A facility policy titled Change in Condition of the Resident dated 9/20/2022, the facility should immediately inform the resident representative when there is a need to alter treatment or a need to discontinue an existing treatment due to adverse consequences, or to commence a new form of treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures regarding notification of change of condition. The DON or designee could educate all appropriate staff on the policies and procedure on notification of change of condition. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results of monitoring to the	20265		05/19/2026

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20265	Continued from page 5 facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		05/19/2026
20270	Use of Oxygen CFR(s): MN Rule 4658.0090 A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to standards of care to prevent respiratory infections for 1 of 1 residents (R16) who required oxygen for chronic respiratory failure with hypoxia (a condition where the lungs are unable to adequately oxygenate the blood). Findings include: R16's quarterly Minimum Data Set (MDS) assessment, dated 2/11/26, identified R15 had intact cognition with no hallucinations, delusions, or rejection of care with admission date of 11/21/25. R16's admission record indicated on 2/18/26, R16's primary diagnosis was end stage renal disease with secondary diagnoses of chronic respiratory failure with hypoxia, biventricular heart failure (heart not working correctly), dependency on supplemental oxygen, unspecified right bundle-branch block (condition where electrical conduction in the heart is impaired), thoracis aortic ectasia (dilation or bulging in aorta in the chest), and atrial fibrillation (heart not beating correctly). Additional secondary diagnosis, dated 1/21/25, included: pulmonary hypertension (high blood pressure in the arteries of the lungs that strains the heart), and pleural effusion (buildup of excess fluid between the layers of the pleura surrounding the lungs). During an interview on 4/6/26 at 4:08 p.m., R16 was observed to be sitting in his wheelchair receiving oxygen via nasal canula from an oxygen concentrator at 2 liters(l)/minute. R16's oxygen tubing did not have a date or label on it. R16 was observed to have a portable oxygen tank on the	20270	Corrected.	05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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20270	Continued from page 6 back of his wheelchair with the oxygen tubing with nasal cannula attached wrapped around it with no date on it. R16 was not sure when the oxygen tubing had been changed. R16's care plan, printed 4/7/26, identified R16 was at risk for respiratory impairment related to chronic respiratory failure with hypoxia with an intervention to administer oxygen per MD orders. The care plan lacked any indication on how often the oxygen tubing should be changed or who would be responsible for changing the oxygen tubing. R16's Order Summary Report, dated 4/6/26, included the following orders: -"2L continuous oxygen via nasal cannula. Concentrator and cylinders with contents and regulators" with a start date of 2/18/26. The Order Summary Report lacked evidence of an order to change oxygen tubing. R16's medication and treatment administration record (MAR/TAR) for 4/1/26 to 4/14/26 included the following orders: -change oxygen tubing and humidifier bottles weekly. Date tubing in the afternoon every Thursday with a start date of 4/16/26. - Change oxygen tubing and humidifier bottles weekly. Date tubing as needed for visibly soiled or known contamination with a start date of 4/9/26. This order had a start date after survey entrance. -Oxygen at 2L/minute via nasal cannula every shift with a start date of 4/9/26 R16's Medication Administration Record and Treatment Administration Record (MAR/TAR) for March 2026 was reviewed and lacked any order for oxygen use or changing of oxygen tubing or oxygen supplies. R16's task log was reviewed and did not include any change of oxygen tubing. R16's progress notes from 3/1/26 through 4/7/26, made no mention of any oxygen tubing having been changed by staff.	20270		05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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20270	Continued from page 7 Observation and interview ON 4/7/26 at 8:29 a.m., of R16 identified he was observed sitting in his room in his wheelchair and reported he just got done eating. R16's oxygen tubing from the oxygen tank on the back of the chair was observed to be partially on the floor with no date on it. R16's oxygen tubing from the concentrator, which R16 was observed wearing, did not have a date on it. R16 stated the facility will change the tubing when it "doesn't fit" but couldn't explain what that meant or when the last time the tubing was changed. At 12:17 p.m., R16 was observed in the dining room for lunch. R16 was observed to have oxygen on via nasal cannula from his portable tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/8/26 at 9:55 a.m., R16 was observed to be leaving the facility. R16 was observed to have nasal cannula on and receiving oxygen from portable oxygen tank located on the back of his wheelchair. The oxygen tubing remained undated or labeled. On 4/9/26 at 2:53 p.m., R16 was observed propelling self in wheelchair in his room. R16 was observed receiving oxygen via nasal cannula from the portable tank located on the back of his wheelchair. The oxygen tubing, including the nasal cannula, from the oxygen concentrator was noted to be laying in a box on the floor. Neither oxygen tubing was dated or labeled. R16 stated he was unsure when the oxygen tubing was last changed. During an interview on 4/9/26 at 2:54 p.m., NA-C stated they are familiar with R16. Staff put oxygen on and off residents including R16. NA-C stated nursing assistants do not change oxygen tubing. NA-C observed R16's oxygen tubing and verified the set of oxygen tubing (from the oxygen tank or oxygen concentrator) was dated or labeled. NA-C stated they are unsure when it was last changed as it was not dated. During an interview on 4/10/26 at 12:54 p.m., nursing assistant (NA)-A stated they do not change the oxygen tubing for residents. Staff only turn the oxygen on and off and do not adjust any settings. NA-A thought it was the nurse's responsibility to change the tubing as nurse aides have never changed oxygen tubing.	20270		05/19/2026

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20270	Continued from page 8 During an interview on 4/10/26 at 1:03 p.m., registered nurse (RN)-A stated oxygen tubing and supplies should be changed weekly to prevent infections and the nurses are responsible for this. During an interview and document review on 4/10/26 at 1:04 p.m., RN-C stated oxygen tubing should be changed weekly, and nurses were responsible for ensuring that was completed. RN-C stated there would be an order to change the oxygen tubing. RN-C stated it was expected to date and label the oxygen tubing also. RN-C reviewed R16's medical record and verified the order to change R16's oxygen tubing was entered on 4/9/16 (after survey entrance) and there was no previous order. RN-C stated it was important to change oxygen tubing to prevent infection and prevent build up in the nasal cannula. During an interview on 4/10/26 at 3:21 p.m., the assistant director of nursing (ADON) stated the expectation was oxygen tubing was changed weekly for infection control purposes as not changing it can contribute to respiratory illnesses. The expectation would be for tubing and all supplies to be dated and labeled. The ADON verified there were no additional nursing or physician's orders prior to 4/9/26, to change R16's oxygen tubing or humidifier bottles and there should have been. On 4/14/26 at 9:53 a.m., the director of nursing (DON) stated the expectation would be oxygen tubing would be changed weekly and as needed to help decrease risk of infection as not changing it can put a resident more at risk for infection. This was to be documented on the MAR/TAR. Review of the current, undated Northwest Respiratory Services instruction sheet for oxygen use the facility used for direction for staff, identified staff were to change tubing every month and the nasal cannula every week. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents' oxygen tubing is changed and dated routinely. The DON or designee could educate all appropriate staff on the policies and procedures	20270		05/19/2026

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20270	Continued from page 9 and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20270		05/19/2026
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement a person-centered care plan for 1 of 1 resident (R5) reviewed for comprehensive care plans. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's hospital discharge summary dated 2/25/26 noted the following: -Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air	20555	Corrected.	05/19/2026

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20555	Continued from page 10 -Skin problem to left heel: clean, dry, intact: treatment offloading and open to air -Skin problem to right heel: clean, dry, intact: treatment open to air R5's current, undated care plan indicated the following: urinary incontinence: report changes in skin integrity found during daily care potential for pressure ulcer development: administer treatments as ordered, and monitor effectiveness follow facility policies/protocols for the prevention/treatment of skin breakdown monitor nutritional status monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth) The need for a feeding tube/potential complications from that tube. R5 was to have no complications from the feeding tube. Staff were to administer formula and hydration and flushes per order. R5's care plan lacked identification of skin breakdown on R5's coccyx; further lacking goals and interventions for monitoring, treating, and documenting R5's actual skin breakdown. Additionally, R5's care plan lacked identification of R5's refusal of cares and treatments; further lacking goals and interventions to apply when R5 refused cares and treatments. R5's care plan lacked identification of R5's risk for fluid-volume imbalances; further lacking goals and interventions for monitoring, treating and documentation. R5's care plan lacked specific time requirements to elevate the head of the bed (HOB) to 30-45 degrees during and after tube feeding. Lastly, R5's care plan lacked specific symptoms and side effects of hypercalcemia, hypothyroidism, and hyperparathyroidism. R5's February, March, and April 2026 treatment administration record (TAR) noted to "Monitor	20555		05/19/2026

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20555	Continued from page 11 Mepilex dressing to buttock daily and change every 3 days and as needed when soiled" beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 is a complicated resident due to her multiple medical problems including hypercalcemia, hypothyroidism, hyperparathyroidism, nausea, vomiting, and gastrectomy tube (g-tube) a device surgically inserted through the belly directly into the stomach to deliver nutrition, fluids, and medications). PA-A stated she would expect to see a care plan for each of these areas. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5 had a Stage I pressure ulcer; her care plan did not reflect any goals or interventions to care for and prevent worsening of the pressure ulcer. DON confirmed R5's care plan only indicated a risk for pressure ulcers; should have identified the actual Stage I pressure ulcer and contain interventions such as encouraging position changes, how often to monitor the coccyx, and treatment directions. The DON stated R5's care plan did not include information about her refusal of cares and treatments. The DON stated this care plan would identify the interventions that could have worked to encourage R5 to follow care and treatment orders. The DON stated R5 did not have a fluid-volume care plan. This care plan would be beneficial so staff could monitor and document fluids; this would be important for the resident since she had a G-tube. The DON stated this resident is complicated, R5's care plan should probably have more detail about her medical conditions so staff could be aware of the symptoms or side effects. The DON stated a complete and comprehensive care plan is important so facility staff could identify, monitor, and treat R5's medical issues. During an interview on 4/8/26 at 2:39 p.m., PA-A stated she would expect a complete and comprehensive care plan; a comprehensive care plan allows the facility to adjust cares and interventions based on R5's needs and desire for treatment. PA-A stated she would specifically expect to see a care plan for skin breakdown, fluid intake-output, refusals of care, and tube feeding	20555		05/19/2026

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20555	Continued from page 12 care. PA-A stated care plans are important because they can be tied into the treatment and medication tasks the facility staff perform; without a specific care plan, staff might not know how to provide specific types of care. A facility policy titled Comprehensive Care Plan dated 9/23/2022, the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. These objectives will be used to monitor the residents' progress. Alternative interventions will be documented, as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		05/19/2026
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to prevent complications	20875	Corrected.	05/19/2026

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20875	Continued from page 13 of enteral feeding and failed to provide appropriate treatment and services for 1 of 1 resident (R5) reviewed who required tube feedings and medication administration through a gastrostomy tube (g-tube). This failure created the likelihood of serious harm for R5, including worsening symptoms of nausea and vomiting, and additional hospital visits. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5 was admitted to the facility on 1/16/26 with an admission diagnosis of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). A review of R5's medical record identified the following hospitalizations/emergency room visits identified on: 1) 2/12/26: R5 was sent to the hospital after a fall with decrease cognition and returned to the facility on 2/22/26; the primary diagnosis was hypercalcemia. R'5 Power of Attorney (POA) was activated during this hospital visit and thereafter due to ongoing intermittent confusion. Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 2/6/26 at 11:31 p.m.: stated she was sick to her stomach, the record lacked provider notification 2/7/26 at 5:13 p.m.: declined oral medication, she did not wish to take them, the record lacked provider notification	20875		05/19/2026

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20875	Continued from page 14 2/7/26 at 10:54 p.m., stated she was feeling nauseous and “just can’t take them,” referring to her medications, which she refused. The record lacked provider notification 2/9/26 at 3:30 p.m.: R5 took her medications through her g-tube but vomited shortly after administration, record lacked provider notification 2/11/26 at 2:07 p.m.: R5 refused all medications stating, her “stomach can’t handle it.” 2/12/26 at 10:13 a.m., sent to emergency room 2) 3/6/26: R5 was sent to the hospital as a result of increased nausea and vomiting and returned to the facility on 3/10/26; the primary diagnosis was hypercalcemia. Record review of R5’s progress notes indicated the following concerns prior to being sent to emergency room: 3/1/26 at 12:33 p.m.: R5’s g-tube was flushed and R5 reported feeling nauseous after flush 3/2/26 at 10:46 a.m.: R5’s g-tube was flushed and R5 reported feeling nauseous after flush 3/3/26 at 2:28 p.m., in-person visit with physician assistant (PA)-A, discussed R5’s ongoing nausea, no new orders written 3/4/26 at 5:28 p.m., notified by hospital team the calcium level is high from recent blood draw, increase cinacalcet to 90 mg, stop vitamin D, push fluids, and repeat calcium level on 3/6/26 3/6/26 at 12:56 p.m.: R5 vomiting again, instruction to send to emergency room 3/10/26 at 4:55 p.m.: POA remains activated 3) 4/6/26: R5 was sent to the emergency room as a result of increased abdominal pain and returned to the facility on 4/6/26; the primary diagnosis was pleural effusion (collection of fluid around your lungs.) Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 3/17/26 6:06 p.m.: R5 experienced nausea and vomiting, no record of provider or POA notification 3/29/26 at 12:07 p.m.: R5 experienced nausea and vomiting after morning medications, no record of	20875		05/19/2026

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20875	Continued from page 15 provider or POA notification 3/30/26 at 12:13 p.m.: R5 experienced nausea and vomiting after morning medications, no record of provider or POA notification 3/31/26 at 3:40 p.m.: R5 experienced nausea and vomiting after medications, no record of provider or POA notification 4/5/26 at 12:00 p.m.: R5 experienced right-sided abdominal pain that continues until 4/6/26 at 12:00 p.m., ongoing nausea, vomiting, pain; resident sent to emergency room 4) 4/8/26: R5 was sent to the hospital and returned to the facility on 4/9/26; the primary diagnosis was right-sided pneumonia (acute inflammation of the lung caused by an infection, commonly caused by aspiration.). Record review of R5's progress notes indicated the following concerns prior to being sent to emergency room: 4/6/26 at 6:00 p.m.: returned from emergency room, R5 was noted to "have a heavy stool burden", R5 refused laxatives, no record of provider or POA notification 4/7/26 at 5:16 a.m.: R5 refused laxatives, no record of provider or POA notification 4/7/26 at 12:22 p.m.: R5 refused laxatives, no record of provider or POA notification 4/7/26 at 8:58 p.m.: R5 stated her upper right quadrant pain is worse, no record of provider or POA notification 4/8/26 at 12:15 p.m.: R5 received daily medications and 150 ml water flush while positioned less than 30 degrees 4/8/26 at 12:42 p.m.: R5 experienced nausea and increased right upper quadrant pain 4/8/26 at 2:38 p.m.: R5 experienced nausea and vomiting after receiving 60 ml of the 150 ml water flush, did not proceed with entire amount due to vomiting, R5's care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order	20875		05/19/2026

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20875	Continued from page 16 -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. Additionally, the care plan lacked assessment and interventions for the risk of fluid volume deficits. R5's provider order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily	20875		05/19/2026

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20875	Continued from page 17 During an interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated R5 has a complicated gastrointestinal (GI) tract. R5 has hyperparathyroidism and this is the source of her hypercalcemia. R5 is no longer a surgical candidate to have her parathyroid removed, symptom management has been the primary direction of care. PA-A stated electrolyte imbalances will be an ongoing concern for R5. PA-A stated she is unsure how often the nutrition team is working with R5 or how involved they are with her care. According to the American Society for Parenteral and Enteral Nutrition article, “Medication via Enteral Feeding Tubes: A Clinician's Guide”, located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities. During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5’s morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 20ml instead of the ordered 15ml.	20875		05/19/2026

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20875	Continued from page 18 Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. At time of administration, RN-A failed to ensure the head of the bed was 30-45 degrees, with the bed remaining at approximately 10 degrees and R5 slouched down in the bed. RN-A stated R5 received a 30ml water flush before medication administration, 30ml water flush in between each medication, and a 150ml water flush at the end of the medication administration. During medication administration, RN-A diluted each medication with approximately 2ml of water, which failed to dilute the medication enough to allow it to pass through the g-tube. When RN-A put the medication into the barrel of syringe attached to the g-tube, the medication was not diluted enough to flow, RN-A then begun adding additional unmeasured amounts of water and continued to add until the medication would flow; 2 medications required pressure from the syringe plunger to flow through the g-tube. During medication administration process, R5 stated she was having increased nausea and abdominal pain. RN-A failed to recognize R5 was still not at the correct position. During administration RN-A failed to flush the g-tube between medications levothyroxine and metoprolol. RN-A was unsure what effect this could have on R5. After administration was completed, RN-A failed to set the head of the bed up to 30-45 degrees; bed remained at approximately 10 degrees with R5 slouched down in bed. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she was unsure how much additional water she had added to dilute medication enough to flow through R5’s g-tube; she guessed it was approximately 5ml. RN-A stated with the complete medication administration and water flushes; R5 had received approximately 450 ml of liquid. RN-A stated she had not had g-tube education for “some time.” RN-A stated the facility had not had a resident that required tube feedings or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had	20875		05/19/2026

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20875	Continued from page 19 been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. When R5 returned to the facility on 3/10/26 her calcium level was 9.5. PA-A stated she expected facility staff to know the basic signs and symptoms of hypercalcemia, including mental status changes, nausea, vomiting, and constipation. PA-A stated she expected the nursing team to follow the standard of practice when administering medication via g-tube, including sitting the head of bed at 30-45 degrees during and after tube feeding and medication administration. Additionally, she was unsure of the amount of water needed to dilute the medication; however, she would anticipate this to be approximately 5-10 ml of water, and the nurse should be keeping track of this to adjust the water flushes during administration. PA-A stated she relies on the pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During observation on 04/08/2026 at 3:09 PM, emergency services arrived at the facility to take R5 to the emergency room; RN-A stated R5 had been experiencing worsening nausea and vomiting and abdominal pain. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. PA-B stated she had included a statement in her discharge summary that stated, “We have asked the staff at your skilled nursing facility (SNF) receive additional education on management of your feeding tube.” PA-B stated she included this statement because R5 had told her she felt the staff at the facility did not know how to use her g-tube. PA-B stated she would expect the facility providers to manage the calcium levels after discharge. PA-B expected the head of the bed to be elevated to 30-45 degrees during and after tube feedings and medication administration. PA-B stated medication interactions should be managed by the facility provider and pharmacist. PA-B stated medication administration times should be assessed by the facility provider and pharmacist. PA-B stated medications given with other medications or around tube feedings can have side effects for R5 that include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. PA-B stated mismanagement of the g-tube with both tube feedings and medication	20875		05/19/2026

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20875	Continued from page 20 administration could result in complications for R5. These complications could include harm, injury, and in worst case, death. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. PH-A stated R5 should be in an upright position during tube feedings and medication administration and up to an hour afterwards. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Additionally, levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. PH-A stated the medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission. During an interview on 4/9/26 at 11:22 a.m., licensed practical nurse (LPN)-B stated R5 had frequent nausea and vomiting. LPN-B stated they only track R5's bowel movements for output. LPN-B stated R5's emesis are not documented in R5's medical record. LPN-B described the process of administering medications via g-tube which did not include elevating head of bed during or after administration of medications or enteral feedings. During an interview on 4/9/26 at 11:42 a.m., registered nurse (RN)-B stated R5 was admitted to her unit at the hospital yesterday evening. Upon arrival at the hospital unit, R5 was nauseous and vomiting. R5 was given medication to resolve these symptoms. RN-B stated she had given R5 her normal medications this morning. RN-B stated the resident has not experienced nausea or vomiting since yesterday. RN-B stated R5 was able to take sips of water or clear liquids without experiencing nausea or vomiting. RN-B stated the resident must be sitting at least 30–45-degree angle during tube feeding and medication administration. RN-B stated if R5 receives tube feeding when not at the correct angle,	20875		05/19/2026

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20875	Continued from page 21 she is at risk for nausea, vomiting, and abdominal pain. Additionally, she would be at a high risk for aspiration or aspiration pneumonia. During an interview on 04/09/2026 at 11:54 AM, PA-C stated frequently monitoring of calcium should be complete weekly until R5's calcium levels are stable, then monthly, then every six months. R5 has been on cinacalcet to manage her high calcium levels; she is on a consistent dose, but ongoing monitoring should still be weekly to bi-weekly. PA-C stated the most common symptoms of hypercalcemia included altered mental status, muscle cramps, and constipation. Nausea and vomiting aren't necessarily a symptom of hypercalcemia; but they are symptoms of the cinacalcet. PA-C stated if R5 was having nausea and vomiting, there is probably another cause for her symptoms. PA-C stated she would expect the facility staff to know the signs and symptoms of hypercalcemia, medication side effects, and how to properly manage the g-tube during tube feedings and medication administration. PA-C stated if R5's g-tube was mismanaged, R5 could be at risk for harm, increasing symptoms of nausea and vomiting and abdominal pain. Additionally, improper positioning during tube feeding and medication administration could result in serious risk for aspiration or other complications. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions; the pharmacy providing the medication will go through the interaction checker; the interaction warnings then get placed on the medication and the medication is delivered to the facility. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing.	20875		05/19/2026

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20875	Continued from page 22 During an interview on 4/7/26 at 3:15 p.m., vice president of success (VPS)-A stated nurses were educated about g-tubes annually and for regular competencies. VPS-A stated nurses can receive g-tube education sporadically; they didn't believe nursing staff were educated about the needs of R5 prior to her arrival. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated she believed the facility provided education to staff about g-tubes but couldn't find the specific education. DON stated she would expect education to be given for g-tubes, tube feeding administration, medication administration, g-tube complications, and g-tube side effects or symptoms. DON stated the facility had not cared for a resident with a g-tube in about a year. DON stated, generally g-tube education is annually, she did not provide g-tube education to staff about this R5 and her specific needs. DON stated it would have been beneficial to have educated staff specifically about R5 so staff could be prepared for any complications. On 4/14/26 at 10:22 a.m., a call was placed to the facility Medical Director; no return call received. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration. A facility policy titled Enhanced Barrier Precautions (EBP) dated 8/8/25, high-contact resident care activities include device care or use: feeding tubes. EBP should be followed when performing high-contact resident care activities. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. A facility policy titled Medical Director Responsibilities dated 4/22/25, the medical director's responsibilities include implementation of resident care policies, such as ensuring physicians and other practitioners adhere to facility policies on	20875		05/19/2026

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20875	Continued from page 23 diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care. A Facility Assessment dated 7/11/25, training and skills unique to resident population: our nurses are trained in enteral feedings; our facility not only conducts a skill assessment during floor orientation of nurses and nursing assistants but also conducts monthly competencies of various skills to ensure that annual training occurs to keep skills honed.	20875		05/19/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to monitor and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 1 of 1 resident (R5) reviewed for pressure ulcers. Findings Include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate	20900	Corrected.	05/19/2026

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20900	Continued from page 24 assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), muscle weakness, type 2 diabetes, hypothyroidism (thyroid gland does not produce enough thyroid hormone, symptoms include fatigue, weight gain, cold intolerance, and depression), hyperparathyroidism (parathyroid gland produces too much hormone, symptoms include high blood calcium levels, feeling weak, nausea, vomiting, loss of appetite, constipation, and abdominal pain), and hypercalcemia (blood calcium level greater than 10.5 milligram (mg) per deciliter (dl) causing fatigue, nausea, vomiting, constipation, confusion, cognitive changes, and irregular heart rhythms). R5's hospital discharge summary dated 2/25/26 noted the following: -Pressure injury to coccyx: red, blanchable: treatment offloading, barrier cream (Zinc, Petroleum) and open to air -Skin problem to left heel: clean, dry, intact: treatment offloading and open to air -Skin problem to right heel: clean, dry, intact: treatment open to air R5's care plan indicated the following: -urinary incontinence: report changes in skin integrity found during daily care -potential for pressure ulcer development: -administer treatments as ordered, and monitor effectiveness -follow facility policies/protocols for the prevention/treatment of skin breakdown -monitor nutritional status -monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound	20900		05/19/2026

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20900	Continued from page 25 size (length x width x depth) R5's care plan lacked resident-specific interventions to prevent or mitigate pressure ulcers that included reposition changes, specialty pressure redistribution boots for heels, toileting program to prevent wet skin, specialty padding for chairs, and barrier protection creams. R5's February, March, and April 2026 treatment administration record (TAR) noted to "Monitor Mepilex dressing to buttock daily and change every 3 days and as needed when soiled" beginning on 2/25/26. February, March, and April TAR lacked additional interventions to prevent or mitigate the worsening of skin issues such as position change schedule, heel protectors, barrier creams, toileting program, and pressure offloading interventions. R5's weekly skin assessments were completed 1/23/26, 1/30/26, 2/7/26, 3/3/26, 3/27/26, and 4/3/26, stating no skin issues. The weekly skin assessments failed to identify R5's coccyx stage I pressure injury, ongoing monitoring, and ongoing assessments. During an interview on 4/7/26 at 11:31 a.m., R5 stated she does have breakdown on her buttocks. R5 stated the staff at the facility put a covering over it every few days; sometimes it gets wet when she is incontinent, so they must replace it then too. R5 is unsure if the skin breakdown is better or worse because she can't see it. Sometimes her buttocks and her heels get sore; but she doesn't get up much so that won't change much. R5 doesn't remember if facility staff have asked her to reposition herself or offered to assist her to reposition. R5 prefers to sit up because she gets nauseous a lot. During an observation and interview on 4/7/26 at 11:47 a.m., physician assistant (PA)-A stated she was not aware R5 had any skin breakdown on her coccyx and awas unaware of fragile skin on her heels. PA-A and the director of nursing (DON) evaluated R5's coccyx, PA-A stated this was a stage I pressure ulcer. Additionally, the mepilex dressing on the coccyx was not placed correctly to prevent further skin breakdown. PA-A stated she would expect to see a pressure ulcer care plan with interventions to prevent further breakdown.	20900		05/19/2026

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20900	Continued from page 26 During an interview on 4/7/26 at 12:02 p.m., DON stated R5 came back from the hospital in February with a stage I pressure ulcer. DON stated the facility ordered the mepilex for her coccyx, but she acknowledged the facility did not update the care plan or TAR to include interventions to prevent or mitigate skin breakdown. DON was unaware about the fragile skin on her heels; acknowledged R5 should have had interventions in place to prevent pressure injuries of her heels. During a follow up interview on 4/7/26 at 3:25 p.m., DON stated R5's care plan was appropriate when she first arrived in January; but should have been updated upon her return in February to include interventions to prevent or mitigate skin breakdown. DON confirmed R5 had a current stage I pressure ulcer. Additionally, the DON confirmed the facility had not been assessing the coccyx weekly since 3/4/26. The DON stated it is important to implement a complete resident-specific care plan to prevent additional skin breakdown and alterations. A facility policy titled Pressure Injuries and Non-Pressure Injuries dated 7/20/22, the facility will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for	20900		05/19/2026

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20900	Continued from page 27 further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		05/19/2026
20930	Rehab - Nasogastric, Gastrostomy tubes CFR(s): MN Rule 4658.0525 Subp. 7 B. Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to monitor daily oral intake and daily output; additionally, the facility failed to develop a system to monitor and assess daily intake and output for 1 of 1 resident (R5) reviewed who required nutritional and hydration support via a gastrostomy tube (g-tube). Findings Include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 required hydration and nutrition via a feeding tube (g-tube). R5’s current face sheet identified diagnoses of moderate protein-calorie malnutrition, dysphagia (difficulty swallowing) requiring the placement of a gastrostomy tube (g-tube) for nutrition and medication administration. R5’s care plan dated 1/26/26 indicated R5 required tube feeding, hydration, and flushes per order, check tube placement prior to meds and feedings, elevating head of bed 30-45 degrees, care of tube per orders, and report signs of aspiration or intolerance of	20930	Corrected.	05/19/2026

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20930	Continued from page 28 feeding. R5's care plan lacked identification for a risk in decreased hydration, lacked the specific signs and symptoms of aspiration, lacked resident-specific interventions to mitigate complications when using the g-tube, and lacked guidance and collaboration for monitoring fluid balance and imbalance. R5's current physician orders included tube feedings (Vital Advanced Formula at 100 milliliters (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150ml of water flush in g-tube after medication administration for the AM medication pass. R5's orders lacked a clear monitoring system for intake and output including urine output, emesis amounts, amount of bowel movement, and amount of oral intake. R5's nutrition assessments dated 1/22/26, 3/2/26, and 3/16/26: section 30 failed to accurately identify how much oral intake the resident received (to adjust free water amounts), section 36 failed to identify gastrointestinal (GI) concerns such as nausea and vomiting, and section 44 failed to identify the amount of emesis the resident experienced (to know when to adjust free water amounts). R5's electronic medical record lacked collaboration, assessments, and outcome about who would be overseeing and managing daily intake and output in relation to the amount of tube feeding and free water flushes R5 should have received to maintain adequate fluid and nutrition. Additionally, the medical record and testing lacked collaboration and follow up to monitor and assess previously known electrolyte imbalances (high calcium, low potassium, high sodium) with a previously low Albumin level of 3.0 (could indicate malnutrition) on 1/6/26. During an interview on 4/7/26 at 11:31 a.m., R5 stated they give her a lot of water during the day and then in the evening they start her tube feedings; she thinks "it is just too much liquid for [her] to handle", and she gets nauseous and vomits at times. R5 stated she wasn't sure who kept track of all that liquid going in, but she felt like it was too much.	20930		05/19/2026

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20930	Continued from page 29 During observation and interview on 4/7/26 at 11:47 p.m., physician assistant (PA)-A had entered R5's room to evaluate her pressure ulcer; upon entering, the resident was vomiting and handed the emesis bag to the nurse. The emesis bag contained approximately 300ml of vomit; a later record review noted this amount was not documented in a treatment administration record (TAR) nor a progress note. Additionally, the TAR and task list did not contain an option to document any output. PA-A stated R5's GI tract was complicated due to her hyperparathyroidism resulting in high calcium levels; symptom management is the primary treatment option as R5 is no longer a surgical candidate. She was "not aware how often nutrition is involved with her care". She was not actively monitoring daily intake and output. She stated she also did not have any laboratory orders for blood draws to assess electrolyte imbalances; "the teams in the hospital might be managing that." During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's tube feeding care plan should have been more resident-specific to include aspects of care such as head-of-bed elevation, medication administration, g-tube complications, and symptoms and side effects. The DON acknowledged they should have been monitoring R5's intake and output more closely, especially the emesis amounts. Fluid balance is important for R5 since she is receiving tube feedings and free water flushes. Staff needed to make sure her hydration and nutrition are adequate. A facility g-tube education titled Enteral Nutrition and Drug Administration dated as provided on 12/22/25, this education failed to identify practice standards for medication administration and tube feeding administration. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for the proper care and to ensure the safe administration of enteral nutrition according to professional standards of practice. Nursing staff could be educated as necessary to the importance of safe administration of enteral feeding to avoid complications and/or infections. The DON or designee could audit nursing staff assigned to residents effected and take that information to the quality assurance performance improvement (QAPI) to ensure compliance and determine the need for further	20930		05/19/2026

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20930	Continued from page 30 education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20930		05/19/2026
20960	Dietary Service - Food Quality CFR(s): MN Rule 4658.0600 Subp. 1 Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 4 of 4 residents (R1, R10, R15, and R30) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchen. Findings include: R1’s quarterly Minimum Data Set (MDS) dated 3/12/26, identified R1 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was independent with eating. During an interview on 4/6/26 at 2:56 p.m., R1 stated the food is cold and he must send it back a lot, it doesn’t matter if he eats in the dining hall or his room; the food is always cold. The facility had the hardest time keeping eggs, mashed potatoes, and beans warm. He stated he has told them so many times and, no one ever does anything about it. During an observation on 4/7/26 at 8:13 a.m., R1 was observed in the dining hall tasting his food (French toast), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R10’s comprehensive Minimum Data Set (MDS) dated 2/10/26, identified R10 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was independent with eating.	20960	Corrected.	05/19/2026

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LA CRESCENT HEALTH SERVICES	**101 SOUTH HILL STREET , LA CRESCENT, Minnesota, 55947**

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20960	Continued from page 31 During an observation on 4/7/26 at 8:18 a.m., R10 was observed in the dining hall tasting his food (French toast, eggs), he motioned for dietary staff to come to his table. R1 asked them to heat up his food. R15's quarterly Minimum Data Set (MDS) dated 2/12/26, identified R15 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required setup/clean up assistance with eating. During an interview on 4/7/26 at 8:40 a.m., R15 stated the food is cold sometimes, and doesn't know why they have such a hard time keeping the food warm, especially when residents are in the dining hall. She has stopped telling staff about the cold food, they don't do anything to change how they keep things hot. R30's quarterly Minimum Data Set (MDS) dated 3/36/26, identified R30 had no cognitive impairment, demonstrated no hallucinations or delusional thinking during the review period, and was required setup/clean up assistance with eating. During an interview and tray tasting on 4/7/26 at 12:37 p.m., dietary manager (DM)-A stated the plate covers in the dining hall, seen this morning, were just started today as a response to complaints of cold food. DM manager tasted food and noted the temperature of the food "seemed appropriate" to her. She does not attend resident council; she "might at some point" but right now she hasn't gone to any of the meetings. It is important to know how residents feel about the food so she can adjust based on their concerns. During an interview on 4/7/26 at 1:15 p.m., ombudsman (OM)-A stated residents at the facility started reaching out to her in October 2025 about the ongoing concerns with food temperatures and food being served cold. She also informed management about food menu options as well. During an interview on 4/13/26 at 10:04 a.m., DM-A stated residents frequently ask for foods to be reheated during meal services. Again, stated the lids on meal plates were started as a response to	20960		05/19/2026

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20960	Continued from page 32 complaints about food temperatures; was unsure if they are helping with temperature or not. During an interview on 4/14/26 at 9:27 a.m., administrator stated she would expect residents to tell any facility staff about cold food. She stated she had not heard any concerns about cold food recently. Additionally, the plate lids weren't necessarily new, they just resumed the practice as an infection prevention method. Due to recent dietary staff changes and recommendations from the regional dietary staff, they had ceased this practice; but now had opted to bring it back. It is important to keep foods warm, so residents enjoy their food. A facility policy titled Food Temperatures dated 8/16/22, food must be cooked to appropriate temperatures, held appropriate temperatures. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure proper temperature for meals served. The facility could update or create policies and procedures, and educate staff on proper temperature for meals served to residents. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure proper temperatures of meals served to residents. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 days	20960		05/19/2026
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 2 of 2 residents (R5, R20) reviewed for transmission-based precautions.	21375	Corrected.	05/19/2026

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21375	Continued from page 33 Findings include: R20’s quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition with no hallucination, delusions or other behavioral symptoms noted and was dependent on staff for activities of daily living (ADLs) except eating which R20 required maximal staff assistance. The MDS indicated R20 had an indwelling catheter. During an observation on 4/8/26 at approximately 7:20 a.m., RN-A was observed to enter R20’s room and performed hand hygiene prior to entering room with hand sanitizer. A plastic bin was observed outside the doorway and inside the bin were personal protective gowns and gloves. Hand sanitizer was available from a dispenser on the wall. On the door, was a single page sign hung indicating "Enhanced Barrier Precautions." Signage was orange in color, CDC (Center for Disease Control and Prevention) emblem on the bottom right corner, two stop signs on the upper right and upper left corners of the page and indicated: " Everyone must: Clean their hands, including before entering and when leaving the room," and "Providers and Staff must also: 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, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wounds Care: any skin opening requiring a dressing." R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A. RN-A performed a respiratory assessment on R20 which included a pulse oximeter reading, and breath sounds. RN-A held R20’s inhaler while she did the treatment, then had R20 rinse her mouth and spit in a cup that RN-A was holding. RN-A prepared R20’s nebulizer and placed the mask on R20’s face. RN-A placed R20’s call light pad on her lap and instructed her to turn her call light on when the treatment was completed. RN-A exited R20’s room and used hand sanitizer. R20’s April medication/treatment administration report (MAR), printed 4/14/26, included the following	21375		05/19/2026

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21375	Continued from page 34 order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR. -Respiratory assessment prior to nebulizer treatment. Document Respirations, Pulse, O2 Sat, and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being documented with code. -Respiratory assessment after nebulizer treatment. Document Respirations, Pulse, O2 Sat, and lung sounds prior to nebulizer treatment two times a day. The record indicated the assessment was completed twice a day as ordered as of the print time of the MAR along with lung sounds being documented with code. -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26. -Catheter care every morning and at bedtime for urinary retention with a start date of 1/20/26. R20's order summary report, dated 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. -Catheter Care every morning and at bedtime for urinary retention starting 1/20/26.	21375		05/19/2026

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21375	Continued from page 35 -Change foley catheter monthly and as needed using a 18Fr silicone indwelling catheter 10cc balloon. One time a day once a month on 18 day of the month and as needed using a 18Fr silicone indwelling catheter 10cc balloon with a start date of 3/18/26. -Irrigate foley catheter daily and as needed with 122 cc. can use tap water or sterile water per facility preference one time a day for catheter care with a start date of 2/20/26. R20's care plan, initiated on 1/20/26, indicated R20 had indwelling urinary catheter. Interventions were all updated on 3/8/26 and included: administer medications per MD order; catheter care; catheter collection bag place din dignity bag holder on b ed/wheelchair; change urinary collection bag as needed; maintain drainage bag below bladder level; report any changes in amount and color, or odor of urine; report to MD signs of UTI (urinary tract infection) such as blood, cloudy urine, fever, increased restlessness, lethargy, complaints of pain or burning. The care plan lacked identification R20 was on enhanced barrier precautions. During an interview on 4/8/26 at 11:50 a.m., RN-A verified they did administer R20's medications 4/8/26 which included a nebulizer, inhaler, oral medications and performed a respiratory assessment. RN-A stated they did not wear a gown and stated they did not touch R20's catheter which was the reason R20 was on EBP. RN-A stated they should have worn a gown since they did a respiratory assessment with the resident and the EBP sign on the door. R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. Prior to medication administration, R5 required enhanced barrier precaution (EBP) due to an indwelling medical	21375		05/19/2026

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21375	Continued from page 36 device (g-tube). RN-A failed to apply the appropriate personal protective equipment (PPE) prior to providing care. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she should have been wearing the appropriate personal protective equipment (PPE) when providing care or administering medications to R5. She stated R5 required enhanced barrier precautions (EBP) and additional PPE (gown and gloves) were needed due to her g-tube. She stated the appropriate PPE is important to prevent the spread of infection from residents to residents. During an interview on 4/14/26 at 9:55 a.m., director of nursing (DON) stated the expectation would be that if a resident on enhanced barrier precautions, the proper PPE would be worn as this helps stop the transmission of infections. DON stated she would expect proper PPE to be worn for a resident on EBP while a respiratory assessment is being performed along with a setting up and administering a nebulizer treatment. A facility policy titled Enhanced Barrier Precautions, dated 8/8/24, identified the facility will implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms and an order for enhanced barrier precautions will be initiated for residents with any of the following: “Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, peripherally inserted central catheters (PICCs), hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MORO. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions.” SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE use. They could also do environmental rounds and audits, and re-education anytime EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement	21375		05/19/2026

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21375	Continued from page 37 (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		05/19/2026
21530	Drug Regimen Review CFR(s): MN Rule 4658.1310 A.B.C A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility	21530	Corrected.	05/19/2026

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21530	Continued from page 38 failed to identify irregularities in monthly drug regimen monitoring review for 1 of 5 residents (R15) reviewed for unnecessary medications who received antipsychotic medications. Additionally, the facility failed to identify potential medication side effects for 1 of 1 resident (R5) reviewed for medication administration. Findings include: R15's quarterly Minimum Data Set (MDS), dated 2/12/26, identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing) During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April. During a record review of R15's pharmacy review and recommendations, the pharmacist failed to address the lack of blood pressure monitoring being completed by staff in the course of their monthly reviews on 11/4/25, 2/5/26, and 4/7/26 for the above-mentioned months. During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her orthostatic blood pressure completed monthly.	21530		05/19/2026

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21530	Continued from page 39 Additionally, if orthostatic blood pressures were ordered, it was her expectation they should get completed monthly. When the consultant pharmacist performed the monthly review of medications, they were to identify when orthostatic blood pressures weren't being completed and should put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible. During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. Additionally, she would expect nursing to complete the orders as written and document why they weren't done. Lastly, since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures. R5 According to the American Society for Parenteral and Enteral Nutrition article, "Medication via Enteral Feeding Tubes: A Clinician's Guide", located at https://nutritioncare.org/wp-content/uploads/2026/04/Medications-Via-EN-Tubes.pdf, identified prior to administering medications through a g-tube, medications should be verified for right client, right medication, right dose, right time, right route, and right documentation. When administering medication through a g-tube, medications should be crushed and diluted with 15-20 milliliters (ml) of purified water separately. Additionally, the head of the bed (HOB) should be elevated at least 30-45 degrees during medication administration and for at least 30-60 minutes after medication administration to prevent aspiration and support safe, effective delivery of medication. Further, proper positioning supports breathing, reduces pressure on the abdomen, and improves resident comfort. Lastly, complications from g-tube misuse can lead to nausea, vomiting, abdominal pain, tube clogging, aspiration, and toxicities.	21530		05/19/2026

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21530	Continued from page 40 R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5's care plan indicated the following: -administer tube feeding formula, hydration, and flushes per order -elevate HOB 30-45 degrees (did not provide direction for when and how long to elevate HOB) R5's care plan lacked resident-specific interventions to monitor or prevent recurrence of nausea, vomiting, and abdominal pain; to include the signs and symptoms of hypercalcemia; which include mental status changes, muscle spasms, abdominal pain, and constipation. R5's phyician's order, dated 1/26/26, included tube feedings (Vital Advanced Formula at 100 milliliter (ml)/hour (hr) for 13 hours) via g-tube. R5 received 150 ml water flush in g-tube every 4 hours, including during tube feeding. R5 received 150 ml of water flush in g-tube after medication administration for the AM medication pass. R5's physician's orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily	21530		05/19/2026

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21530	Continued from page 41 -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily -ascorbic acid (vitamin C) 500 mg via g-tube daily During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated the resident had been experiencing ongoing nausea and vomiting with intermittent abdominal pain since returning from the hospital on 3/10/26. Additionally, she relies on the consultant pharmacist to know what medication can be given at what times in relation to the tube feeding and on the pharmacy team to tell her if there are any specific medication interactions. During an interview on 4/9/26 at 8:53 a.m., PA-B stated she was the hospitalist who cared for R5 during her 3/6/26 to 3/10/26 hospital admission. Additionally, medication interactions should be managed by the facility provider and pharmacist. Further, medication administration times should be assessed by the facility provider and pharmacist. Medications given with other medications or around tube feedings can have side effects for R5 that include nausea, vomiting, abdominal pain, increased absorption, or decreased absorption. During interview on 4/9/26 at 9:59 a.m., pharmacist (PH)-A stated the hours and times of administration are determined by the facility provider, pharmacist, and manufacturer guidelines. Medication interactions should be managed by the facility provider and pharmacist. If medication interactions aren't completed, R5 could experience ineffective medications, medication side effects, and symptom side effects. PH-A stated medications such as prednisone should be taken with food to prevent nausea and vomiting. Medications such as levothyroxine, in this situation, should have been given before the tube feedings were started or several hours after tube feedings have stopped. Levothyroxine should be spaced at least 4 hours from the iron vitamin solution and the omeprazole solution. The medication errors should have been identified by the facility provider and pharmacist upon medication review at time of admission.	21530		05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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21530	Continued from page 42 During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated when a resident has been admitted to the facility, she reviews the discharge summary to verify medications and compare them to the facility medication administration record (MAR). If she notices any discrepancies, she will write a recommendation for the provider to review and determine appropriateness of medication; she would expect response from the provider in one week. PH-B stated she does not evaluate each medication for interactions. PH-B stated she doesn't check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist could develop and/or revise policies to monitor medications for adequate monitoring to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. Audits could be	21530		05/19/2026

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21530	Continued from page 43 developed to monitor medications for adequate monitoring. The DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further education. TIME PERIOD FOR CORRECTION: 21 DAYS	21530		05/19/2026
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure what occurs when a person stands up after sitting or lying down) was completed for 1 of 1 resident (R15) reviewed for unnecessary medication use and who consumed antipsychotic medication. Findings include:	21535	Corrected.	05/19/2026

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21535	Continued from page 44 Review of the 7/24/24, Olanzapine guidelines, located at: https://www.drugs.com/olanzapine.html#side-effects, identified olanzapine may cause serious side effects such as low blood pressure. Common side effects of olanzapine that affect 5% or more people who take it include postural hypotension (a drop in blood pressure when going from a lying or sitting position to standing). R15's quarterly Minimum Data Set (MDS), dated 2/12/26, identified R15 had no cognitive impairment and demonstrated no hallucinations or delusional thinking during the review period. Further, the MDS recorded R15 consumed antipsychotic, antidepressant, and antianxiety medications. During a record review, R15's orders reflected showed R15 received olanzapine 10 milligrams (mg) every evening before bedtime. Additionally, orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review, R15's orders reflected orthostatic BP laying, sitting, and standing; documented in the electronic medical record on the 9th of every month. During a record review of R15's orthostatic blood pressures from October 2025 through April 2026 identified there were no orthostatic blood pressures completed in October, January, March, or April During a record review of R15's pharmacy review and recommendations indicated the following. In: -4/7/26: did not address orthostatic blood pressures not done in March 2026 or April 2026 -2/5/26: did not address orthostatic blood pressure not done in January 2026 -11/4/26: did not address orthostatic blood pressure not done in October 2026 During an interview on 4/7/25 at 3:25 p.m., director of nursing (DON) stated R15 is currently taking an antipsychotic medication and should have her	21535		05/19/2026

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21535	Continued from page 45 orthostatic blood pressure completed monthly. Additionally, if orthostatic blood pressures are ordered, it is her expectation they get completed monthly. When the consultant pharmacist performs the monthly review of medications, she would identify when orthostatic blood pressures aren't being completed and would put the reminder to complete them in her monthly recommendations. Lastly, orthostatic blood pressure measurements are important so that staff can identify adverse medication effects as soon as possible. During an interview on 04/15/2026 at 11:46 a.m., pharmacist (PH)-B stated when she completes the medication monthly review, she would review the orders to make sure there was an order to complete orthostatic blood pressures, not necessarily whether they were completed. She would expect nursing to complete the orders as written and document why they weren't done. Since it isn't routine for her to check the actual completion of orthostatic blood pressures, she would not put in the monthly medication review to remind staff to complete them. PH-B stated orthostatic blood pressure monitoring can be important because you can identify medication issues if a resident has positive orthostatic blood pressures. A policy titled Use of Psychotropic Medications, dated 4/27/25 showed the effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: upon physician evaluation, during the pharmacist's monthly medication review, during the MDS review, and in accordance with nurse assessments and medication monitoring parameter consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental,	21535		05/19/2026

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21535	Continued from page 46 physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		05/19/2026
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be	21545	Corrected.	05/19/2026

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21545	Continued from page 47 filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a medication administration error rate of less than 5 percent (%) resulting in an 8.57 % medication error rate, identified during 3 of 25 medication administration observations. Findings include: R5’s quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had moderate cognitive impairment with no rejection of care. R5 required hydration and nutrition via a feeding tube (g-tube). R5’s physician’s orders included: -levothyroxine (thyroid medication) 88 micrograms (mcg) via g-tube daily (instruction to give on an empty stomach and not with 4 hours of iron supplements or antacids) -prednisone (steroid) 4 milligrams (mg) via g-tube daily (instruction to take with food) -iron-vitamins oral liquid 15 ml via g-tube daily (instruction to take on an empty stomach or with food if it upsets stomach. -folic acid (vitamin) 1 mg via g-tube daily -apixaban (blood thinner) 2.5 mg via g-tube twice daily	21545		05/19/2026

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21545	Continued from page 48 -metoprolol tartate (blood pressure) 12.5 mg via g-tube twice daily -senna (laxative) 8.6 mg via g-tube twice daily -cinacalcet (overactive parathyroid) 30 mg via g-tube twice daily -omeprazole-syrspend (antacid) SF Akla oral suspension 10 ml daily (prepped 15ml) -ascorbic acid (vitamin C) 500 mg via g-tube daily During an observation on 4/8/26 at 9:39 a.m., registered nurse (RN)-A prepared R5's morning medication administration. RN-A removed and prepped the above-named medications and put each medication in a medication cup. RN-A did not know when the most recent tube feeds had completed. RN-A failed to identify the medication levothyroxine had a pharmacy warning to give on an empty stomach and not within 4 hours of iron supplements (prepped iron-multivitamin suspension) or antacids (prepped omeprazole suspension), which she was preparing to administer at the same time. RN-A failed to identify prednisone should be given with food (tube feeding ended at 5:42 AM.) RN-A failed to identify iron-multivitamin suspension should be given on an empty stomach. Additionally, RN-A prepped the iron-multivitamin suspension with 15 ml instead of the ordered 10 ml. During an interview on 4/8/26 at 10:36 a.m., RN-A stated she had not had g-tube education for "some time." RN-A stated the facility had not had a resident that required tube feedings with medication administration or had a g-tube for about a year or year and a half. RN-A stated she had been taking care of R5 since her admission in January. RN-A stated she should have read the pharmacy alerts on the medications. She acknowledged she should have verified the liquid dose a 2nd time to make sure she had the right amount of the liquid. During an interview on 4/9/26 at 11:22 a.m., assistant director of nursing (ADON) stated the process to administer medication includes verifying the right resident, right dose, right route, right drug, and right time. She stated if the individual medications have a pharmacy alert such as take with food, don't give with certain medications; it is an expectation you follow those drug administration	21545		05/19/2026

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21545	Continued from page 49 guidelines. She stated if you don’t follow those recommendations, medications could be less effective, more effective, cause side effects, or not be effective at all. During an interview on 4/15/26 at 11: 46 a.m., pharmacist (PH)-B stated she doesn’t check when medications are administered in relation to the tube feedings; she would expect nursing to follow the administration directions from the pharmacy. PH-B stated it is important to follow the administration directions from pharmacy; but could not speak to the importance of accurate medication administration timing. During an interview on 4/14/26 at 9:35 a.m., the administrator stated the medication regulation is facilities should have less than a 5% error rate. The facility’s medication error rate of 8.57% is above the acceptable regulation standard. Staff should be confirming the five medication rights (right resident, right dose, right route, right drug, and right time) and it is an expectation staff should follow the pharmacy directions on each medication package. If staff can’t follow the direction of medication from pharmacy, they are expected to reach out to pharmacy or the resident’s provider to get order administration clarification. She stated the importance of performing medication administration accurately is to maintain patient safety. A facility policy titled Medication Administration dated January 2026, medications are administered in accordance with written orders of the prescriber. Timing of medication administration must align with manufacturer specifications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of time to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits could be taken to the quality assurance performance improvement (QAPI) committee to determine compliance or the need for continued monitoring.	21545		05/19/2026

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21545	Continued from page 50 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		05/19/2026
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and care plan to ensure competency and safety with self-administration of medication for 1 of 1 resident (R20) observed to be self-administering medication in their room. Findings include: R20's quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, identified R20 had intact cognition. On 4/8/26 at approximately 7:20 a.m., R20 was observed sitting in her Broda chair (a type of positioning chair) in her room. R20 was administered her morning oral medications by registered nurse (RN)-A along with an inhaler after performing a respiratory assessment. RN-A prepared R20's nebulizer and placed the mask on R20's face. RN-A placed R20's call light pad on her lap and instructed her to turn her call light on when the treatment was completed. R20 stated she always puts the light on when she was finished with the treatment. On 4/8/26 at 7:52 a.m., assistant director of nursing (ADON) told RN-A that she had removed R20 nebulizer mask and performed the post - respiratory assessment. R20's April medication/treatment administration report (MAR), printed 4/14/26, included the following order:	21565	Corrected.	05/19/2026

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21565	Continued from page 51 -Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligram(mg)/3millilter(ml) (a combination of two medications in one solution used to help open airways and prevent worsening of airflow obstruction) - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The record indicated the medication was administered twice a day as ordered as of print date of MAR. The MAR lacked evidence that R20 was able to administer the medication independently after staff set up. R20's order summary report, dated 4/14/26, included the following order: -Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml - 1 dose inhale orally two times a day related to chronic respiratory failure with hypoxia with a start date of 3/12/26. The order summary report lacked an order or evidence that R20 was able to administer the medication independently after staff set up. R20's care plan, with an initiation date of 4/8/26 (after survey entrance) for self-administration of medications/treatments indicated "nurse to set up Neb and place mask on resident for resident to complete without supervision. Nurse to return to take mask off and complete prost respiratory assessment when treatment is complete." The care plan lacked evidence of identification of R20 being assessed and able to self-administer nebulizer prior to 4/8/26. R20's entire medical record was reviewed and lacked any assessment, physician order, or care planning which demonstrated R20 had been evaluated for their ability to self-administer medication. During an interview on 4/8/26 at 11:50 a.m., RN-A stated if a resident was cognitively aware, then the resident could be left alone with a nebulizer after set up. RN-A stated we know our residents and who can be left alone with nebulizer treatments. RN-A verified that R20 was left alone in her room with her nebulizer treatment this morning and this was the facility practice. RN-A stated R20 was able to push	21565		05/19/2026

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21565	Continued from page 52 her call light when the treatment was completed to have the mask removed. RN-A stated a self-administration assessment should be completed for residents who self-administer medications. RN-A verified an assessment had not been completed for R20. During an interview on 4/8/26 at 11:56 a.m., ADON verified she had turned off R20's nebulizer treatment earlier today and removed her nebulizer mask. ADON verified R20 had been in her room alone. ADON stated if a resident was left in their room while completing a nebulizer treatment, it would be expected a self-administration of medication assessment would be completed as this would be self-administration of medication. ADON verified this had not been completed for R20. ADON stated she was going to complete an assessment. During an interview on 4/14/26 at 9:58 a.m., director of nursing (DON) stated the expectation would be if a resident was left with a nebulizer, a self-administration of medication assessment would be completed as it's important because the residents have to have the knowledge and understanding of what the medications is used for and why. DON stated they must be properly assessed. A facility policy titled Medication Administration Self-Administration by resident, reviewed 1/26, identified "residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. Facilities must adhere to state specific laws and regulations." Furthermore, the document identified an assessment will be conducted to assess the resident's cognitive, physical and visual ability to carry out the responsibility. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental	21565		05/19/2026

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21565	Continued from page 53 ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		05/19/2026
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident;	21830	Corrected.	05/19/2026

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21830	Continued from page 54 (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to notify 1 of 1 resident's (R5) representative (also the Power of Attorney) when R5 was sent to the emergency department after a fall, and for repeated refusals of care upon her return to the facility.	21830		05/19/2026

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21830	Continued from page 55 Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. During a record review, R5's dismissal summary from the 2/12/26 hospitalization; the hospital physician stated, "R5 is unable to receive and evaluate information effectively and communicate decisions necessary to manager her health. I recommend that the provisions contained in her Power of Attorney for Health Care be activated". During a record review, R5's POA was activated at the facility upon return from the 2/12/26 hospitalization. R5's care plan failed to address R5's refusals of care; additionally, the care plan failed to provide direction, so staff knew when to notify provider and POA about refusals of care and medications. R5's orders failed to address R5's refusals of care; additionally, the orders lacked direction, so staff knew when to notify the medical providers and POA about refusals of care and medications. During record review, R5 refused medications or treatment on the following dates after the POA was activated: -3/6/26: refusal to have blood drawn, no POA notification -4/6/26: refused weight measurements, no POA notification -4/7/26 at 5:16 a.m.: refused constipation medication, no POA notification	21830		05/19/2026

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21830	Continued from page 56 -4/7/26 at 12:22 p.m.: refused constipation medication, no POA notification -4/7/26 at 8:58 p.m.: R5 stated her pain was worse, no POA notification -4/8/26 at 4:58 a.m.: R5 stated her pain had gotten worse, refused all bowel medications, no POA notifications. During record review, there was no documentation R5's POA had been notified prior to leaving the facility to go to the Emergency Room (ER) on 2/12/26 after suffering a fall at the facility. During an interview on 4/7/26 at 3:25 p.m., director of nursing (DON) stated R5's POA was activated when she returned from the hospital on 2/22/26. DON stated the POA was activated when R5 was in the hospital because R5 had increasing periods of confusion and lack of understanding about her medical status. DON confirmed R5 has been intermittently refusing cares or treatments since the beginning of February. DON stated the facility doesn't notify the POA of refusals but probably should if the resident doesn't understand her condition or how the meds work. The DON stated it is important to notify the POA about refusal of cares and treatments, so the POA knows the treatments R5 is or isn't receiving. Attempted phone call to speak with R5 POA made on 4/7/26 at 10:45 a.m. During an interview on 4/8/26 at 2:39 p.m., physician assistant (PA)-A stated she was aware R5 had intermittently been refusing medications. PA-A stated she would expect to be notified of ongoing refusals. PA-A stated R5 did not have an order to notify facility providers or POA of refusals of cares or treatments. PA-A stated notification to the POA is important, so the POA understands what treatments R5 isn't getting and why. Additionally, the POA may have some influence with R5 and encourage R5 to accept the cares and treatments. A facility policy titled Change in Condition of the Resident dated 9/20/2022, identified the facility should immediately inform the resident's representative when there is a need to alter	21830		05/19/2026

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21830	Continued from page 57 treatment or a need to discontinue an existing treatment due to adverse consequences, or to commence a new form of treatment. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee should develop and implement measures to ensure timely notification to the physician. The facility should update policies and procedures, educate staff on those changes, and perform measurable audits to ensure the needs of resident(s) are maintained. The facility should report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		05/19/2026
21925	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 29 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the Office of the State Long-Term Cate (LTC) Ombudsman for 2 of 2 residents (R5 and	21925	Corrected.	05/19/2026

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21925	Continued from page 58 R39) reviewed for hospitalizations and discharges. Findings include: R5's quarterly Minimum Data set (MDS) dated 3/19/26, indicated R5 had clear speech, no hearing disabilities, and used corrective lenses. R5 had moderate cognitive impairment with no rejection of care. R5 had no impairments of her upper extremities and used a walker. R5 was independent with eating, required set up/clean up assistance with oral hygiene, and required partial to moderate assistance with toileting, showering/bathing, dressing, and personal hygiene. R5 had occasional urinary incontinence but was always continent of bowel. R5's face sheet indicated R5 was originally admitted to the facility on 1/16/26. R5 was hospitalized on 2/12/26 and 3/6/26. R5's Progress notes lacked any communication with the ombudsman after each hospitalization. Review of the notices to the Ombudsman, provided by the facility, identified the notice sent on 3/8/26 did not include R5's hospitalizations. During an interview on 4/7/26 at 12:52 p.m., ombudsman (OM)-A stated she had received a notification from the facility on 3/8/26; this notification contained information about hospitalizations, transfers, and discharges from November and December. OM-A stated she has not received any other notifications for the months of January, February, and March. During an interview on 4/10/26 at 10:22 a.m., social services (SS)-A stated he is responsible for sending notification to the ombudsman about hospitalizations, transfers, and discharges; these notifications are supposed to be sent monthly. SS-A confirmed he is "behind a little with submitting" the notifications to the ombudsman. SS-A stated ombudsman notification are important, so residents have advocate if they feel they have been wrongly hospitalized, transferred, or discharged. R39's admission Minimum Data Set (MDS)	21925		05/19/2026

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21925	Continued from page 59 assessment, dated 2/17/26, identified R39 had moderately impaired cognition and required moderate to maximum staff assistance with activities of daily living (ADLs). R39's diagnoses included: displaced fracture of the base of the left femur, hip fracture, coronary artery disease (heart disease), heart failure (heart not functioning properly), hypertension (high blood pressure), and diabetes mellitus (condition where the body's ability to manage glucose is impaired). R39's progress dated 2/11/26 to 3/6/26 identified a progress note dated 2/11/26 at 10:53 a.m., indicated R39 was admitted to the facility. Another progress noted dated 3/6/26 at 5:43 p.m., indicated R39 discharged home to a new apartment from the facility. The progress notes lacked any communication with ombudsman during planning process of R39's discharge. Review of the notices to the Ombudsman, provided by the facility, identified a notice sent on 3/8/26 did not include R39. During an interview on 4/13/26 at 9:56 a.m., social services (SS)-A stated that he had worked with R39 for her planned discharge. SS-A stated R39 had a case manager who also assisted with the discharge. SS-A stated he had not coordinated with the ombudsman or updated the ombudsman that R39 was planning to discharge prior to discharge. SS-A was unsure if he updated the ombudsman after R39 discharged. If R39 was not on the list provided to surveyors that was sent to the ombudsman's office the beginning of March, then the ombudsman had not been notified. A facility policy titled Transfer and Discharge (including AMA), reviewed 7/15/22, identified for non-emergency transfer or discharges which were initiated by the facility and return not anticipated, a copy of notice shall be provided to a representative of the Office of the State Long-Term Care Ombudsman. Furthermore, instances of emergency transfers/discharges, the social services director or designee, shall provide notice of transfer to a representative of the State Long-term Care Ombudsman via monthly list. SUGGESTED METHOD OF CORRECTION: The Director of Social Work or designee could review	21925		05/19/2026

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21925	Continued from page 60 facility policies and procedures for transfer and discharge notification, and develop a system to ensure the ombudsman is given notice when the facility initiates a resident transfer. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		05/19/2026