



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 15, 2026

Administrator
Franklin Restorative Care Center
900 3RD STREET SOUTH
FRANKLIN, MN 55333

RE: CCN:245273

Cycle Start Date: April 23, 2026

Dear Administrator:

On April 23, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 23, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 23, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



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May 15, 2026

Administrator
Franklin Restorative Care Center
900 3RD STREET SOUTH
FRANKLIN, MN 55333

Re: State Nursing Home Licensing Orders

Event ID: 1F35A4- H1

Dear Administrator:

The above facility survey was completed on April 23, 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/22/2026	
NAME OF PROVIDER OR SUPPLIER Franklin Restorative Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH , FRANKLIN, Minnesota, 55333			
(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 on 04/22/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Franklin Restorative Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			05/22/2026

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

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Franklin Rehabilitation and Health Care Center was constructed as follows: The original building was constructed 1962, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1994, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a capacity of 40 beds and had a census of 33 at the time of the survey.			K0000			05/22/2026

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K0000 Bldg. 01	Continued from page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			05/22/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.1.1(4). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/22/2026 at 8:57 AM, it was revealed by a			K0918	How the corrective action will be accomplished for identified affected individuals. The facility immediately arranged for the emergency generator system to receive follow-up evaluation by a licensed electrician in accordance with the recommendation provided by Interstate Power Systems. All required generator maintenance, testing, and inspections had been completed; however, the recommendation for additional electrical evaluation to ensure the system was not overloaded had not yet been completed. The recommended evaluation was scheduled and supporting documentation will be maintained appropriately. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents had the potential to be affected. The facility reviewed all generator maintenance, testing, inspection, and vendor recommendation records to ensure all required follow-up actions and recommendations were completed timely and documented appropriately. What systemic changes will ensure that the deficient practice will not recur. The facility reviewed and revised its tracking process for generator maintenance, testing, inspections, vendor recommendations, and required follow-up actions. The Maintenance Director/designee was educated on regulatory requirements, vendor recommendation follow-through expectations, and documentation compliance related to NFPA 99 and NFPA 110 requirements. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will audit generator maintenance records, inspection reports, and vendor recommendations monthly for three months to ensure all recommended follow-up actions are completed and documented. Findings will be reviewed through the QAPI process.		06/12/2026

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K0918 SS = F Bldg. 01	Continued from page 3 review of available documentation at the time of the survey that the facility could not provide documentation showing the deficiencies listed on the emergency generator load bank test were corrected. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0918	Continued from page 3 D: 06/12/2026		06/12/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain Patient Care Related Electrical Equipment per NFPA 99 (2012 edition), Health Care Facilities Code. Sections 10.3, 10.5.2, 10.5.2.1.2 and 10.5.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/22/2026 at 9:36 AM, it was revealed by a			K0921	How the corrective action will be accomplished for identified affected individuals. The facility immediately arranged for inspection of all Patient-Care Related Electrical Equipment (PCREE) and obtained updated inspection documentation to ensure equipment safety and compliance. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents had the potential to be affected. The facility reviewed all PCREE throughout the facility to verify inspections were completed and documentation was current. What systemic changes will ensure that the deficient practice will not recur. The facility implemented a tracking system for annual PCREE inspections and required documentation. The Maintenance Director/designee was educated on inspection requirements and documentation expectations. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will add the PCREE inspection yearly date to the Tels System ensure continued compliance. Findings will be reviewed through the QAPI process. 06/12/2026		06/12/2026

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K0921 SS = F Bldg. 01	Continued from page 4 review of available documentation and staff interview that the facility could not provide documentation showing that Patient-Care Related Electrical Equipment (PCREE) had been inspected within the last year. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0921			06/12/2026
K0211 SS = E Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.1.10.1, 7.2.1.5.1, and 7.2.1.5.3. These deficient findings could have a patterned impact on the occupants within the facility. Findings include: On 04/22/2026 at 9:50 AM, it was revealed by observation that the courtyard exit gate was equipped with a locking device on the non-egress side. 2. On 04/22/2026 at 10:05 AM, it was revealed by observation that the double doors located at the nurse's station locked when tested, preventing a means of egress. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0211	How the corrective action will be accomplished for identified affected individuals. The facility immediately removed the locking device from the non-egress side of the courtyard exit gate and corrected the nurse's station double doors to ensure they allowed free egress at all times. The affected egress doors were tested to confirm proper operation and resident safety. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents, staff, and visitors had the potential to be affected. The facility conducted a full audit of all egress doors and exit pathways throughout the building to ensure doors functioned properly and allowed free egress in accordance with Life Safety Code requirements. What systemic changes will ensure that the deficient practice will not recur. The facility implemented routine egress door inspections as part of the maintenance and life safety program. The Maintenance Director/designee was educated regarding Life Safety Code egress requirements and the importance of maintaining unobstructed and functional exits at all times. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will conduct weekly audits of egress doors and exit pathways for two weeks, then monthly x one month to ensure continued compliance. Findings will be reviewed through the QAPI process. D: 06/12/2026		06/12/2026

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K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed			K0222	How the corrective action will be accomplished for identified affected individuals. The facility installed the required signage on the delayed egress door located at the therapy entrance to ensure compliance with Life Safety Code requirements. The door and signage were tested and verified for proper visibility and function. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents, staff, and visitors had the potential to be affected. The facility conducted an inspection of all delayed egress doors throughout the facility to ensure required signage was present, visible, and compliant with regulatory requirements. What systemic changes will ensure that the deficient practice will not recur. The facility added delayed egress door signage checks to the routine maintenance and life safety inspection process. The Maintenance Director/designee was educated on Life Safety Code requirements related to delayed egress doors and required signage. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will conduct weekly audits of delayed egress doors and required signage for two weeks, then monthly x one month to ensure continued compliance. Findings will be reviewed through the QAPI process. D: 06/12/2026		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/22/2026	
NAME OF PROVIDER OR SUPPLIER Franklin Restorative Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH , FRANKLIN, Minnesota, 55333			
(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
K0222 SS = E Bldg. 01	Continued from page 6 in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, and 7.2.1.6.1.1(4). This deficient finding could have a patterned impact on the residents within the facility. Findings Include: On 04/22/2026 at 10:18 AM, it was revealed by observation and staff interview, that the delayed egress door located at the therapy entrance did not have a readily visible sign that read "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS." An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0222			06/12/2026
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or			K0324	How the corrective action will be accomplished for identified affected individuals. The facility immediately removed the power cord from the residential stove located in the Therapy Room to prevent use until compliant safety measures are installed in accordance with Life Safety Code requirements. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents had the potential to be affected. The facility conducted a review of all cooking devices throughout the facility to ensure required safety mechanisms and protections were in place and functioning properly.		06/12/2026

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K0324 SS = E Bldg. 01	Continued from page 7 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.3(9), 19.3.2.5.4, 19.3.2.5.5, 9.2.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/22/2026 at 10:13 AM, it was revealed by observation that the residential stove located in the Therapy Room does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0324	Continued from page 7 What systemic changes will ensure that the deficient practice will not recur. The facility implemented routine inspections of all cooking devices and associated safety equipment as part of the maintenance and life safety program. The Maintenance Director/designee was educated regarding Life Safety Code requirements related to residential cooking equipment and required safety controls. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will conduct weekly audits of cooking devices and required safety features for two weeks, then monthly x one month to ensure continued compliance. Findings will be reviewed through the QAPI process. D: 06/12/2026		06/12/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 04/22/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Franklin Restorative Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			05/22/2026

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

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Franklin Rehabilitation and Health Care Center was constructed as follows: The original building was constructed 1962, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1972, is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1994, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a capacity of 40 beds and had a census of 33 at the time of the survey.			K0000			05/22/2026

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K0000 Bldg. 01	Continued from page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			05/22/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.1.1(4). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/22/2026 at 8:57 AM, it was revealed by a			K0918	How the corrective action will be accomplished for identified affected individuals. The facility immediately arranged for the emergency generator system to receive follow-up evaluation by a licensed electrician in accordance with the recommendation provided by Interstate Power Systems. All required generator maintenance, testing, and inspections had been completed; however, the recommendation for additional electrical evaluation to ensure the system was not overloaded had not yet been completed. The recommended evaluation was scheduled and supporting documentation will be maintained appropriately. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents had the potential to be affected. The facility reviewed all generator maintenance, testing, inspection, and vendor recommendation records to ensure all required follow-up actions and recommendations were completed timely and documented appropriately. What systemic changes will ensure that the deficient practice will not recur. The facility reviewed and revised its tracking process for generator maintenance, testing, inspections, vendor recommendations, and required follow-up actions. The Maintenance Director/designee was educated on regulatory requirements, vendor recommendation follow-through expectations, and documentation compliance related to NFPA 99 and NFPA 110 requirements. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will audit generator maintenance records, inspection reports, and vendor recommendations monthly for three months to ensure all recommended follow-up actions are completed and documented. Findings will be reviewed through the QAPI process.		06/12/2026

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K0918 SS = F Bldg. 01	Continued from page 3 review of available documentation at the time of the survey that the facility could not provide documentation showing the deficiencies listed on the emergency generator load bank test were corrected. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0918	Continued from page 3 D: 06/12/2026		06/12/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain Patient Care Related Electrical Equipment per NFPA 99 (2012 edition), Health Care Facilities Code. Sections 10.3, 10.5.2, 10.5.2.1.2 and 10.5.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/22/2026 at 9:36 AM, it was revealed by a			K0921	How the corrective action will be accomplished for identified affected individuals. The facility immediately arranged for inspection of all Patient-Care Related Electrical Equipment (PCREE) and obtained updated inspection documentation to ensure equipment safety and compliance. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents had the potential to be affected. The facility reviewed all PCREE throughout the facility to verify inspections were completed and documentation was current. What systemic changes will ensure that the deficient practice will not recur. The facility implemented a tracking system for annual PCREE inspections and required documentation. The Maintenance Director/designee was educated on inspection requirements and documentation expectations. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will add the PCREE inspection yearly date to the Tels System ensure continued compliance. Findings will be reviewed through the QAPI process. 06/12/2026		06/12/2026

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K0921 SS = F Bldg. 01	Continued from page 4 review of available documentation and staff interview that the facility could not provide documentation showing that Patient-Care Related Electrical Equipment (PCREE) had been inspected within the last year. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0921			06/12/2026
K0211 SS = E Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.1.10.1, 7.2.1.5.1, and 7.2.1.5.3. These deficient findings could have a patterned impact on the occupants within the facility. Findings include: On 04/22/2026 at 9:50 AM, it was revealed by observation that the courtyard exit gate was equipped with a locking device on the non-egress side. 2. On 04/22/2026 at 10:05 AM, it was revealed by observation that the double doors located at the nurse's station locked when tested, preventing a means of egress. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0211	How the corrective action will be accomplished for identified affected individuals. The facility immediately removed the locking device from the non-egress side of the courtyard exit gate and corrected the nurse's station double doors to ensure they allowed free egress at all times. The affected egress doors were tested to confirm proper operation and resident safety. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents, staff, and visitors had the potential to be affected. The facility conducted a full audit of all egress doors and exit pathways throughout the building to ensure doors functioned properly and allowed free egress in accordance with Life Safety Code requirements. What systemic changes will ensure that the deficient practice will not recur. The facility implemented routine egress door inspections as part of the maintenance and life safety program. The Maintenance Director/designee was educated regarding Life Safety Code egress requirements and the importance of maintaining unobstructed and functional exits at all times. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will conduct weekly audits of egress doors and exit pathways for two weeks, then monthly x one month to ensure continued compliance. Findings will be reviewed through the QAPI process. D: 06/12/2026		06/12/2026

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K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed			K0222	How the corrective action will be accomplished for identified affected individuals. The facility installed the required signage on the delayed egress door located at the therapy entrance to ensure compliance with Life Safety Code requirements. The door and signage were tested and verified for proper visibility and function. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents, staff, and visitors had the potential to be affected. The facility conducted an inspection of all delayed egress doors throughout the facility to ensure required signage was present, visible, and compliant with regulatory requirements. What systemic changes will ensure that the deficient practice will not recur. The facility added delayed egress door signage checks to the routine maintenance and life safety inspection process. The Maintenance Director/designee was educated on Life Safety Code requirements related to delayed egress doors and required signage. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will conduct weekly audits of delayed egress doors and required signage for two weeks, then monthly x one month to ensure continued compliance. Findings will be reviewed through the QAPI process. D: 06/12/2026		06/12/2026

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K0222 SS = E Bldg. 01	Continued from page 6 in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, and 7.2.1.6.1.1(4). This deficient finding could have a patterned impact on the residents within the facility. Findings Include: On 04/22/2026 at 10:18 AM, it was revealed by observation and staff interview, that the delayed egress door located at the therapy entrance did not have a readily visible sign that read "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS." An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0222			06/12/2026
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or			K0324	How the corrective action will be accomplished for identified affected individuals. The facility immediately removed the power cord from the residential stove located in the Therapy Room to prevent use until compliant safety measures are installed in accordance with Life Safety Code requirements. How will other individuals with the potential to be affected or in similar situations be identified and protected. All residents had the potential to be affected. The facility conducted a review of all cooking devices throughout the facility to ensure required safety mechanisms and protections were in place and functioning properly.		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 04/22/2026	
NAME OF PROVIDER OR SUPPLIER Franklin Restorative Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH , FRANKLIN, Minnesota, 55333			
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K0324 SS = E Bldg. 01	Continued from page 7 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.3(9), 19.3.2.5.4, 19.3.2.5.5, 9.2.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/22/2026 at 10:13 AM, it was revealed by observation that the residential stove located in the Therapy Room does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0324	Continued from page 7 What systemic changes will ensure that the deficient practice will not recur. The facility implemented routine inspections of all cooking devices and associated safety equipment as part of the maintenance and life safety program. The Maintenance Director/designee was educated regarding Life Safety Code requirements related to residential cooking equipment and required safety controls. How the facility will monitor its corrective actions/performance. The Maintenance Director or designee will conduct weekly audits of cooking devices and required safety features for two weeks, then monthly x one month to ensure continued compliance. Findings will be reviewed through the QAPI process. D: 06/12/2026		06/12/2026

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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 4/20/26 to 4/23/26, 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: NO licensing orders were issued.			20000			05/22/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 H52731515C (IQIES #2569283) H52731516C (IQIES #1142556) H52731517C (IQIES #1142562) H52731518C (IQIES #2622284) The following complaint was reviewed: An incidental finding was discovered and issued at 21931. H52731514C (iQIES #2624065) 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			20000			05/22/2026

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20000	Continued from page 2 OF MINNESOTA STATE STATUTES/RULES.		20000			05/22/2026	
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure medications were coded accurately on the Minimum Data Set (MDS) assessments for 2 of 5 residents (R11 and R29) reviewed for unnecessary medications. Findings include: R11's face sheet printed 4/22/26, indicated diagnoses of type two diabetes with complications, alcohol abuse, and weakness. R11's quarterly MDS dated 4/16/26, indicated intact cognition, no rejection of care, use of wheelchair, independent with dressing and hygiene, and section N identified R11 took an anticoagulant. R11's physician's orders printed 4/22/26, did not include an anticoagulant but did include and order for aspirin oral capsule 81mg by mouth one time a day. R11's care plan revised 4/16/26, did not include mention of an anticoagulant medication. R29's face sheet printed 4/22/26, indicated diagnoses of chronic respiratory failure, repeated falls, and systolic heart failure. R29's quarterly MDS dated 4/7/26, indicated intact cognition, rejection of care one to three days, use of wheelchair, partial assistance with hygiene, substantial assistance with lower body dressing, and section N identified R29 took an anticoagulant. R29's physician's orders printed 4/22/26, included an order for aspirin oral tablet delayed release 81mg by mouth one time a day, but did not include an order for an anticoagulant medication. R29's care plan revised 4/7/26, did not include		20550	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R11 MDS was modified on 3/31/2026 by MDS coordinator R29 MDS dated was modified on 3/31/2026 by MDS coordinator Education was provided to the MDS coordinator on 5/21/2026 by the Director of Clinical Reimbursement on the Conducting and Accurate Resident Assessment Policy. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents taking Aspirin have the potential to be affected An audit of residents coded to be on an anticoagulant was completed on 3/31/2026 by Director of Clinical Reimbursement to ensure all were coded correctly What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Duties of the in-house MDS coordinator were adjusted that she would no longer be completing the MDS on 6/1/2026 MDS to be completed by remote MDS coordinator who holds a certification on completion of the MDS on 6/1/2026 to ensure accuracy of assessments completed going forward. An Audit will be conducted on 1 MDS weekly x 8 weeks to ensure accuracy of coding by MDS coordinator.		06/12/2026	

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20550	Continued from page 3 mention of an anticoagulant medication. During interview on 4/21/26 at 9:29 a.m., registered nurse (RN)-A stated she thought the aspiri taken by both R11 and R29 could be counted as an anticoagulant medication on the MDS assessment. RN-A stated she would clarify with the person who trained her. After clarification, RN-A stated aspirin should be coded as an antiplatelet medication, not an anticoagulant medication. RN-A further stated the MDS was coded incorrectly and she would submit corrections. During interview on 4/22/25 at 2:08 p.m., interim director of nursing stated he would expect the MDS to be coded correctly based on the resident assessment instrument (RAI) directions to ensure accurate representation of resident needs. Facility Conducting an Accurate Resident Assessment policy dated 1/2026, stated accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status using the appropriate RAI instructions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review and revise the process to ensure medications are coded correctly on the Minimum Data Set (MDS) assessment. The DON or designee could educate staff on the process. In addition, the DON or designee could determine a specific timeframe to conduct monitoring audits to ensure compliance. The DON or designee could take the results of the education and audits to the QAPI (quality assurance and performance improvement) committee to ensure appropriate oversight and/or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20550	Continued from page 3 Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026
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.			20875	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R5 blood glucose readings and current orders were reviewed with MD on 5/22/2026 Blood Glucose machines were calibrated on 5/26/2026 per manufacturer guidelines		06/12/2026

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20875	Continued from page 4 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to report elevated blood glucose levels per provider order for 1 of 1 residents (R5) reviewed for insulin. In addition, the facility failed to calibrate blood glucose monitors according to manufacturer instructions for 1 of 1 residents (R5) reviewed for insulin. Further, the facility failed to ensure monitoring of skin wounds for 1 of 1 resident (R22) reviewed for non-pressure skin conditions. Findings include: ELEVATED BLOOD GLUCOSE AND CALIBRATION OF MONITOR R5's face sheet received on 4/22/26, included diagnoses of diabetes with hyperglycemia (elevated blood sugar). R5's annual Minimum Data Set (MDS) assessment dated 2/6/26, indicated intact cognition, clear speech, could understand and be understood. R5 was independent with most activities of daily living, did not walk and could propel wheelchair independently. R5's provider order dated 7/31/25, indicated blood sugar checks two times a day. Order dated 6/21/21, indicated staff were to notify provider if BS (blood sugar) was <70 or >400. R5's care plan dated 8/16/21, indicated R5 had diabetes and his blood sugars would remain within normal limits through next review. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of R5's electronic medical record (EMR) indicated in March and April 2026, two of R5's fingerstick blood sugars had been in excess of 400 mg (milligram)/dl (deciliter) without documentation that a provider had been notified. On 3/31/26 at 9:00 a.m., blood sugar had been 536 mg/dl On 4/3/26 at 4:40 p.m., blood sugar had been 421 mg/dl A provider note dated 3/17/26, (prior to documentation of the elevated blood sugars) indicated R5 had presented for evaluation of type 2			20875	Continued from page 4 Order to monitor skin for s/s of infection r/t skin picking initiated for R22 on 4/29/2026 Skin check completed on R22 on 5/12/2026 indicates no skin issues. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents who are diabetic have the potential to be affected. All residents with wounds have the potential to be affected Blood glucose readings for past 30 days audited with high readings reviewed by NP on 5/26/2026 A full house skin sweep was completed on in-house residents on 5/15/2026 with any residents found to have wounds or open areas referred to wound care for evaluation and appropriate monitoring initiated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with Licensed clinical staff on 5/26/2026 on Notification of Changes Policy, Skin Assessment Policy, Blood Glucose Monitoring Policy with all licensed clinical staff being educated by 6/11/2026. Any licensed clinical staff not receiving education by 5/11/2026 will not be allowed to work until receiving education. Audit will be completed 3/week x 4 weeks, then 2/week x 4 weeks, then weekly x 4 weeks or until substantial compliance is maintained to ensure blood glucose quality control checks are completed per policy. Blood Glucose out of range will be reviewed daily Monday – Friday as part of the daily clinical standup		06/12/2026

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20875	Continued from page 5 diabetes. Recent A1c (blood test that measures average blood sugar levels over the past two or three months) was 8.8% (normal = 5.7%). Minor adjustments to diabetes medications had been made and R5 would continue to be monitored closely. During an interview on 4/23/26 at 10:30 a.m., regional clinical consultant (RCC)-D looked in R5's EMR and verified the two blood sugars greater than 400 mg/dl. RCC-D also verified there had not been an order for a sliding scale (where insulin dosages were adjusted based on blood sugar levels), nor had there been documentation nursing staff notified a provider of the blood sugars greater than 400 mg/dl. RCC-D stated she would have expected nursing staff to follow provider orders, inform the provider of the elevated blood sugars and potentially receive new orders. Further, RCC-D was informed nursing staff did not know if glucometers were being calibrated per manufacturer instructions, something that would be considered with abnormally high blood sugars checks. RCC-D stated she would expect glucometers to be calibrated and would check on it. At 10:41 a.m., RCC-D stated she could not see evidence glucometers where being calibrated. During an interview on 4/23/26 at 10:45 a.m., trained medication aide (TMA)-A stated she did not know anything about glucometer calibration. During an interview on 4/23/26 at 12:10 a.m., licensed practical nurse (LPN)-B who had earlier stated she did not think glucometers were calibrated, obtained R5's glucometer from the medication cart and the brand was Arkray Assure Platinum. Together with LPN-B, looked in medication room for evidence glucometers had been calibrated. LPN-B found unopened boxes of control solutions with expiration dates of 2027, but no binder or other documentation that indicated calibration was being done. During a telephone interview on 4/23/26 at 3:13 p.m., licensed practical nurse (LPN)-A recalled R5's blood sugar greater than 500 mg/dl at the end of March. LPN-A admitted she did not call the provider to notify him, but may have sent the provider an electronic message, however, could not say for certain. LPN-A acknowledged the importance of following provider orders and notifying a provider with a significantly elevated blood sugar to allow the provider to make medication adjustments if necessary. During a telephone interview on 4/23/26 at 3:48 p.m., advanced practice registered nurse (APRN)-F did not recall being informed of R5's elevated blood			20875	Continued from page 5 process with elevated blood glucose readings over the weekend reviewed on Monday to ensure appropriate notifications are made and follow up completed. Immediate education up to and including corrective action will be provided to nurses failing to do proper notifications. Audit will be completed 3/week x 4 weeks, then 2/week x 4 weeks, then 1/week x 4 weeks on 5 random residents weekly skin check to ensure appropriate monitoring and interventions are initiated for any newly identified areas. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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20875	Continued from page 6 sugars greater than 400 mg/dl in March and April. APRN-F stated the reason it was good to be notified for anything over 400 mg/dl was so action could be taken, such as a one-time dose of insulin. Informed there had been an order to inform the provider of blood sugars great than 400 mg/dl – he was not aware of that and stated he would expect nursing staff to follow provider orders and/or facility policy. Facility Blood Glucose Monitoring policy dated 2023, indicated the facility would perform blood glucose monitoring as per physician's orders and report critical test results to the physician timely. Calibration checks on glucometers must be performed _____ (this space was left blank) as per manufacturer’s instructions. Manufacturer Instructions: The Quality Assurance/Quality Control Reference Manual with revised date of 10/24, found on website (Assure Platinum® Blood Glucose Meter - ARKRAY USA, Inc.) for the Arkray Assure Platinum glucometer, indicated, the user should check meter and test strips using Assure® Dose Control Solutions (Normal-Level 1 and High-Level 2) to confirm the meter and test strips are working properly, or to check if testing correctly. Assure Dose Control Solutions contain known amounts of glucose and are used to check that the meter and the test strips are working properly. The test strip bottles have Assure Dose Control Solution ranges printed on the labels. Compare the result displayed on the meter to the Assure Dose Control Solution range printed on the test strip bottle. Before using a new meter or a new bottle of test strips, conduct a control solution test following the procedure with two different levels of control solutions (Normal-Level 1 and High-Level 2). USE CONTROL SOLUTION • To test technique. • Before testing with the meter for the first time. • When opening a new bottle of test strips. • When suspecting the meter or test strips may not be functioning properly. • If the test results appear to be abnormally high or low or are not consistent with clinical symptoms. • When the meter has been dropped or stored below 32°F (0°C) or above 122°F (50°C). • The test strip bottle has been left open or has been exposed to light, temperatures below 39°F (4°C) or above 86°F (30°C), or humidity levels above 80%. • Each time the batteries are changed. NON-PRESSURE SKIN CONDITION R22’s face sheet printed 4/22/26, indicated diagnoses of mild cognitive impairment, weakness,			20875			06/12/2026

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20875	Continued from page 7 mood disorder, and excoriation skin-picking disorder. R22's annual MDS assessment dated 3/17/26, indicated intact cognition, no behaviors or rejection of care, use of wheelchair, dependent for personal hygiene and dressing, and no pressure ulcers, open lesions, or wounds. R22's physician's order dated 3/8/25, indicated weekly skin review on bath day every Sunday. R22's care plan printed 4/22/26, indicated potential for impairment to skin integrity related to obesity with goal of maintaining intact skin by review date. Apply medications as directed when ordered for skin treatments. Keep skin clean and dry. Use lotion on dry skin. Do not use wet wipes. During observation and interview on 4/20/26 at 3:11 p.m., R22 was awake in her bed. R22 had four small scabs (0.1cm to 0.4cm) and 3 scabs (0.3cm to 0.6cm) on her left arm. R22 had one larger scab (0.7cm) on her right arm that she was actively picking open. R22 stated nurses did not check on her scabs, put medication on them, or ask her what they were from. R22 stated she always had scabs. R22's weekly bath audits dated 4/5/26 and 4/12/26, indicated no skin alterations or open areas, other than wound to coccyx. During interview on 4/22/26 at 11:59 a.m., TMA-B stated she was aware of R22's skin-picking and her multiple scabs. TMA-B stated she thought they used to monitor the scabs and document it on the treatment record, but they no longer did that. TMA-B stated they used to use a cream on her scabs but she didn't see that ordered anymore either. TMA-B stated those areas would normally be documented and monitored on weekly bath audits but she did not see them documented for R22. During interview on 4/22/26 at 12:07 p.m., LPN-C stated R22 had a bath on 4/19/26, and she didn't see that R22's scabs were documented or assessed at that time. LPN-C stated she did not see any monitoring or treatment for R22's scabs on her physician's orders. During interview on 4/22/26 at 12:32 p.m., interim director of nursing (DON) stated he was aware of R22's skin-picking diagnosis but was not sure if they were monitoring or treating her scabs. DON stated he didn't think they were doing anything for the scabs. DON stated if R22 had wounds from			20875			06/12/2026

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20875	Continued from page 8 skin-picking he would expect them to be monitored for signs of infection and worsening to prevent future injury or illness for R22. Facility Skin Assessment policy printed 4/22/26, indicated a full body skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for three, and weekly thereafter. Documentation of skin assessment: document observation, types of wounds, other information as indicate SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review and revise policies and procedures, if necessary, to ensure physician orders are followed for informing providers of elevated blood glucose levels. In addition, polices and procedures could be reviewed and revised as needed to ensure skin monitoring is completed for non-pressure skin conditions. The DON or designee could re-educate staff on expectations. Further, staff could be educated on manufacturer instructions for calibrating glucometers. In addition, the DON or designee could determine a specific timeframe to conduct monitoring audits to ensure compliance. The DON or designee could take the results of the education and audits to the QAPI (quality assurance and performance improvement) committee to ensure appropriate oversight and/or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20875			06/12/2026	
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.		20900	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R4 was evaluated by wound care practitioner on 5/18/2026 with treatment orders updated. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents with wounds have the potential to be affected An audit was conducted on the TARS of all residents with wounds for missed documentation of wound care on 5/28/2026 with education provided		06/12/2026	

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20900	Continued from page 9 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to follow provider orders for wound care dressing changes for 1 of 1 resident (R4) reviewed for pressure injury. Findings include: R4's face sheet provided on 4/22/26, included diagnoses of paraplegia (paralysis causing impairment of motor sensory function of lower extremities) and pressure ulcers to right and left buttock. R4's annual Minimum Data Set (MDS) assessment dated 2/18/26, indicated intact cognition, clear speech, could understand and be understood. No behaviors. Pressure ulcer to sacral region. Independent with most activities of daily living. Mobility per motorized wheelchair. R4's provider orders dated 4/22/26, indicated: sacrum dressing: cleanse coccyx with wound cleanser. Place calcium alginate (absorbent dressing used primarily for managing exudate in wounds) in wound bed. Place barrier cream around peri-wound. Cover with ABD (abdominal pad) and tape down. Two times a day, start 4/22/26. R4's care plan dated 11/23/21, indicated R4 had a pressure injury stage 4 to coccyx, and that R4's pressure injuries would show signs of healing and remain free from infection by/through review date of 6/17/26. R4 requested his bed as flat as possible to reduce shear and preferred to be repositioned independently. Care plan with revised date of 4/21/23, indicated staff to administer treatments as ordered and monitor for effectiveness. Provide treatment at times requested by resident. R4 preferred to sleep in every day. R4 was seen by wound care provider on 4/21/26, with subsequent note documented at 3:38 p.m.: Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 4, full thickness skin and tissue loss. Wound was present on admission.			20900	Continued from page 9 to nurses failing to document completion of wound care. Skin Sweep was completed on all in-house residents on 5/15/2026 with any residents found to have wounds or open areas referred to wound care for evaluation and appropriate treatment orders updated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with licensed clinical staff on Wound Treatment Management Policy and Documentation of Wound Treatments Policy by DON/Designee on 5/26/2026 with all licensed clinical staff receiving education by 6/11/2026. Any licensed clinical staff not receiving education by 6/11/2026 will not be allowed to work until education is received. Audits will be completed on the TARS of residents with wounds will be completed 3/week x 4 weeks, then 2/week x 4 weeks, then 1/week x 4 weeks or until substantial compliance is obtained. Immediate education up to and including corrective action to nurses failing to document wound care Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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20900	Continued from page 10 No signs and symptoms of infection. Measurements: Length 10.18 cm (centimeters). Width 9.6 cm. Depth 0 cm. Area (cm2): 72.33 cm. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous. Nursing progress note dated 4/22/26 at 12:52 p.m., indicated new wound care orders received on 4/21/26: Discontinue previous wound care orders, cleanse coccyx wound BID (twice a day) with wound cleanser, place calcium alginate (absorbent dressing used primarily for managing exudate in wounds) in wound bed, place barrier cream around peri wound, cover with ABD and tape down. During an interview on 4/23/26 at 9:10 a.m., LPN-C was shown R4's treatment administration record (TAR) for the day prior, 4/22/26, which indicated R4's dressing which had been ordered to be changed twice a day had not been changed at all. One space on the TAR was blank and the other indicated the number seven, which LPN-C stated meant R4 had been sleeping. In addition, the TAR indicated a daily dressing change to the coccyx had not been done on 4/15/26. LPN-C verified the dates where a dressing change had not been documented as being done and could not speculate as to why they had not been done. During an interview and observation on 4/23/26 at 9:44 a.m., in R4's room, LPN-C stated generally R4 prioritized his wound care and she was not aware of him refusing dressing changes. LPN-C stated she generally talked to R4 at the start of her shift and the two agreed upon a time to do the dressing change. While LPN-C was preparing supplies for the dressing change, R4 stated his dressing had not been changed since the provider changed it on 4/21/26. R4 stated he didn't know why the nurse on duty had not changed it the evening prior. R4 stated he rarely refused care and did not mind if staff woke him to change his dressing. R4's sacral wound was significant and covered nearly the entirety of both buttocks and was approximately the size of a woman's hand. Minimal exudate observed, flesh and pink in color. No odor. LPN-C changed the dressing according to the orders. During an interview on 4/23/26 at 1:02 p.m., regional clinical consultant (RCC)-D was informed a twice a day dressing changes had not been done at all on 4/22/26. RCC-D stated she would have expected staff to have completed dressing changes			20900			06/12/2026

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20900	Continued from page 11 on 4/22/26, as ordered by the provider, and especially since the provider changed the wound care orders on 4/21/26, potentially indicating previous orders were not effective. During a telephone interview on 4/23/26 at 3:48 p.m., advanced practice registered nurse (APRN)-F was informed after his visit to R4 on 4/21/26, and changing the R4's dressing change orders, R4's dressing had not been changed until today, 4/23/26. APRN-F stated he expected staff to perform R4's dressing changes as ordered. APRN-F stated he changed the order because R4 had been having problems with his skin from the Mepilex (a dressing with absorbent foam and an adhesive border) so he changed the order to cloth tape. In addition, APRN-F stated he added calcium alginate to the dressing change orders to absorb more of the drainage, adding R4's wound had seemed to plateau in healing, and therefore, "Important to stay on top of it." Facility Wound Treatment Management policy dated 2023, indicated to promote wound healing of various types of wounds, it was the policy of the facility to provide evidence -based treatments in accordance with current standards of practice and physician orders. Wound treatments would be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Treatments would be documented on the treatment administration record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review and revise policies and procedures, if necessary, to ensure wound care is provided as ordered by the physician. The DON or designee could re-educate staff on expectations. In addition, the DON or designee could determine a specific timeframe to conduct monitoring audits to ensure compliance. The DON or designee could take the results of the education and audits to the QAPI (quality assurance and performance improvement) committee to ensure appropriate oversight and/or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20900			06/12/2026
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			21375	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R4 was evaluated by wound care practitioner on		06/12/2026

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21375	Continued from page 12 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 the infection prevention and control program included ongoing surveillance, analysis, and trending of resident and staff infections and failed to implement and maintain an effective infection prevention and control program specific to antibiotic stewardship. The facility did not have a system to track antibiotic use, culture results, organisms identified, or antibiotic resistance to ensure residents received appropriate treatment, Additionally, the facility failed to maintain knowledge of a current list of reportable communicable diseases, including when and to whom communicable diseases, healthcare-associated infections, and potential outbreaks must be reported. This had the potential to affect all 34 residents who resided in the facility. In addition, the facility failed to ensure adherence to enhanced barrier precautions (EBP) when nursing staff failed to wear personal protective equipment (gowns) when providing direct care to 2 of 2 residents (R4, R22) reviewed for pressure wounds. Findings include: INFECTION CONTROL PROGRAM/ COMMUNICABLE DISEASE LIST Review of the Infection Surveillance Report dated 1/1/26–3/31/26 revealed documentation that included resident name, room number, infection onset date, signs and symptoms, status, and pharmacy orders. However, the report contained missing data related to signs and symptoms and lacked evidence of analysis of infections and illnesses, including identification of patterns or trends, implemented interventions, and required precautions. The facility was unable to provide documentation demonstrating analysis, trending, or evaluation of infection data. Review of the Employee Line List printed 4/22/26 included employee name, department, title, date, and symptoms. The documentation lacked evidence of analysis of infections or illnesses, including patterns or trends, interventions implemented, and precautions required. The facility did not provide evidence of trending or analysis of staff infection data.			21375	Continued from page 12 5/18/2026 with treatment orders updated. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents with wounds have the potential to be affected An audit was conducted on the TARS of all residents with wounds for missed documentation of wound care on 5/28/2026 with education provided to nurses failing to document completion of wound care. Skin Sweep was completed on all in-house residents on 5/15/2026 with any residents found to have wounds or open areas referred to wound care for evaluation and appropriate treatment orders updated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with licensed clinical staff on Wound Treatment Management Policy and Documentation of Wound Treatments Policy by DON/Designee on 5/26/2026 with all licensed clinical staff receiving education by 6/11/2026. Any licensed clinical staff not receiving education by 6/11/2026 will not be allowed to work until education is received. Audits will be completed on the TARS of residents with wounds will be completed 3/week x 4 weeks, then 2/week x 4 weeks, then 1/week x 4 weeks or until substantial compliance is obtained. Immediate education up to and including corrective action to nurses failing to document wound care Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is		06/12/2026

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21375	Continued from page 13 On 4/21/26 at 11:21 a.m., registered nurse (RN)-A, identified as the Infection Preventionist and employed at the facility for approximately one month, stated infections were tracked within the electronic medical record (EMR). RN-A reviewed EMR data for February and March 2026 and confirmed the data did not include comprehensive information such as signs and symptoms and primarily included infections associated with medication orders. RN-A confirmed gaps existed in the infection surveillance process and that some data was missing from tracking logs. RN-A further stated that monthly analysis of infections and illnesses is important to identify trends or patterns and to initiate interventions such as staff education and process improvements. RN-A also confirmed lack of awareness of a current list of reportable communicable diseases and was unable to describe the reporting protocol, including communication with local or state public health officials or identification of reportable outbreaks. On 4/22/26 at 11:49 a.m., the interim director of nursing (DON) and RN-A stated they were not aware of employee illness tracking processes. Both indicated that tracking employee illness would be important to identify symptoms and determine necessary precautions within the facility. The DON acknowledged the facility is expected to follow regulatory requirements related to infection surveillance. RN-A stated it is important for the infection preventionist to track employee illnesses to identify potential correlations with resident infections. On 4/22/26 at 12:32 p.m., the administrator stated the facility maintained a document tracking employee illnesses; however, the information had not been shared with RN-A and confirmed the data was not utilized for trending or analysis of staff infections. The facility Infection Prevention and Control Program Policy dated 3/5/25, indicated : Surveillance: A system of surveillance is utilized for prevention identifying reporting investigating and controlling infections and communicable diseases for all resident, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a civility assessment and accepted national standards. The infection preventionist serves as a leader in surveillance activities, maintains documentation of			21375	Continued from page 13 maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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21375	Continued from page 14 incidents, findings, and any other corrective actions made by the facility and report surveillance findings to the facilities quality assessment and assurance committee. The RNS and LPNS participate in surveillance through assessment of residents and reporting changes and conditions to the residents physicians and management staff per protocol for notification of changes and in-house reporting of communicable diseases and infections. EBP R4's face sheet provided on 4/22/26, included paraplegia (paralysis causing impairment of motor sensory function of lower extremities), pressure ulcers to right and left buttock and neuromuscular dysfunction of bladder (loss of bladder control due to disease or injury). R4's annual Minimum Data Set (MDS) assessment dated 2/18/26, indicated intact cognition, clear speech, could understand and be understood. Pressure ulcer to sacral region. Indwelling supra-pubic catheter (tube inserted into bladder through abdominal incision to drain urine). Independent with most activities of daily living. Mobility per motorized wheelchair. R4's provider orders included: 10/31/21: foley catheter 4/22/26: sacrum dressing: cleanse coccyx with wound cleanser. Place calcium alginate (absorbent dressing used primarily for managing exudate in wounds) in wound bed. Place barrier cream around peri-wound. Cover with ABD (abdominal pad) and tape down. Two times a day. No orders for enhanced barrier precautions (EBP). R4's care plan with revised date of 4/7/26, indicated R4 had a pressure injury stage 4 to coccyx, and that R4's pressure injuries would show signs of healing and remain free from infection by/through review date. Care plan dated 4/21/23, indicated R4 had an indwelling suprapubic catheter with history of chronic infections and had a history of ESBL (a bacteria) resistance in urine. The care plan did not indicate R4 had been in EBP. During an interview on 4/22/26 at 10:36 a.m., observed an EBP sign on R4's door. No cart outside the door containing personal protective equipment			21375			06/12/2026

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21375	Continued from page 15 (PPE) including gowns. R4 had been lying in bed. When asked for permission to observe his dressing change, R4 stated he wanted to wait. Without asking, R4 stated, "Staff don't wear gowns when they empty my catheter or change my dressing – they never do." Observed two large, plastic, three-drawer organizers in R4's room and did not see any gowns. One tall, plastic doffing receptable was observed on top of one of the three-drawer organizers in the corner and hard to reach. Inside the receptable was one non-disposable blue gown. During an interview and observation on 4/23/26 at 8:50 a.m., when asked to observe his dressing change, R4 stated, "You won't see anything." When asked what he meant, stated staff will do what they are supposed to do – they will wear gowns. Again, looked around the room and did not see any PPE gowns. The receptable to doff reusable gowns still had only one blue gown in it for the past two days despite staff emptying urinary catheter bag each shift. In addition, the doffing receptable was still on top of the three-drawer supply bin and hard to reach, potentially indicating lack of use. During an interview and observation on 4/23/26 at 9:17 a.m., nursing assistant (NA)-B stated she was aware R4 was in EBP and stated she needed to wear PPE when she emptied R4's urine bag. NA-B could not recall the last time she emptied his bag. When asked where R4's PPE gowns were, NA-B stated they were in his room. Together went into R4's room. NA-B looked around and stated there were none. NA-B stated he was supposed to have a cart outside his room with gowns in it. When asked where staff put gowns when they take them off, NA-B pointed to the receptable on top of the three-drawer organizer and said that shouldn't be there. The receptable was removed and shown to NA-B who confirmed the cloth inside was one, blue reusable PPE gown. NA-B acknowledged there should have been more gowns in the receptable because staff emptied R4's urine bag every shift and changed his dressing every day. During an interview and observation on 4/23/26 at 9:44 a.m., together in R4's room, licensed practical nurse (LPN)-C was asked to locate the PPE gowns used for emptying R4's catheter and changing his dressing. LPN-C looked around the room and stated there were none, adding gowns and gloves should have been available outside R4's door. During an interview and observation on 4/23/26 at 10:02 a.m., together with RN-A who was also the infection preventionist, entered R4's room. RN-A			21375			06/12/2026

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21375	Continued from page 16 verified R4 had been on EBP and verified a PPE cart had not been located outside of R4's door. RN-A stated residents in EBP should have a PPE cart outside their door and did not know what had happened to R4's. RN-A was asked to locate PPE gowns in the room and stated there were none. RN-A was asked if the doffing receptable was in an appropriate location and stated it was not. R4 who was lying in bed, informed RN-A staff never wore gowns to empty his urine or change his dressing. RN-A admitted to not noticing the lack of a PPE cart outside or R4's room and to not monitoring staff for adherence to EBP guidelines. During an observation on 4/23/2026 at 10:28 a.m., upon exiting R4's room, observed a PPE cart outside of R4's room and a doffing receptable just inside R4's room. Facility Enhanced Barrier Precautions policy with revised date of 3/5/25, indicated staff received training on EBP upon hire and annually, and were expected to comply with all designated precautions. An order for EBP would be obtained for residents with chronic wounds and urinary catheters. Gowns and gloves were immediately available near or outside of the residents room. PPE for EBP was only necessary when performing high-contact care activities. A trash can was to be positioned inside the room and near the exit to discard PPE after removal and prior to exit. The infection preventionist performed periodic monitoring of adherence to determine the need for additional training. High-contact resident care activities included wound care and device care including urinary catheters. R22's face sheet printed 4/22/26, indicated diagnoses of mild cognitive impairment, weakness, mood disorder, and excoriation skin-picking disorder. R22's annual MDS assessment dated 3/17/26, indicated intact cognition, no behaviors or rejection of care, use of wheelchair, dependent for personal hygiene and dressing, and no pressure ulcers, open lesions, or wounds. R22's physician's order dated 3/8/25, indicated weekly skin review on bath day every Sunday. R22's physician's order dated 3/20/26, indicated cleanse coccyx wound. Cover with foam dressing. Replace every other day. R22's care plan printed 4/22/26, indicated potential for impairment to skin integrity related to obesity with goal of maintaining intact skin by review date.			21375			06/12/2026

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21375	Continued from page 17 Apply medications as directed when ordered for skin treatments. Keep skin clean and dry. Use lotion on dry skin. Do not use wet wipes. During interview on 4/20/26 at 3:09 p.m., R22 stated she had a pressure ulcer on her coccyx. R22 stated she did not recall staff wearing gowns when changing her brief or providing wound care. During observation and interview on 4/21/26 at 11:10 a.m., LPN-A completed R22's wound order. LPN-A removed R22's brief, cleansed her wound, and applied foam dressing. LPN-A did not wear a gown while completing wound care. LPN-A stated she was unsure if she needed to wear a gown while completing wound care for R22, and stated she did not see an enhanced barrier precautions (EBP) sign on R22's door or an EBP supply cart outside her room. LPN-A stated she would normally expect to wear a gown while completing a dressing change on a pressure ulcer. During observation on 4/21/26 at 3:15 p.m., R22's door had a new sign indicating EBP should be worn in her room when providing cares and had an EBP cart with gowns placed outside her door. During interview on 4/22/26 at 12:32 p.m., interim director of nursing (DON) stated he would expect EBP to be used for wounds that required a dressing to prevent spread of infection. Facility Enhanced Barrier Precautions policy with revised date of 3/5/25, indicated staff received training on EBP upon hire and annually, and were expected to comply with all designated precautions. An order for EBP would be obtained for residents with chronic wounds and urinary catheters. Gowns and gloves were immediately available near or outside of the residents room. PPE for EBP was only necessary when performing high-contact care activities. A trash can was to be positioned inside the room and near the exit to discard PPE after removal and prior to exit. The infection preventionist performed periodic monitoring of adherence to determine the need for additional training. High-contact resident care activities included wound care and device care including urinary catheters. ANTIBIOTIC STEWARDSHIP Review of the Infection Prevention and Control (IPC) case list dated 1/1/26-3/31/26, , documentation included resident name, room number, onset date, signs and symptoms, current prescription, prescriber, infection type, organism, diagnosis, and			21375			06/12/2026

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21375	Continued from page 18 category. However, the log lacked documentation of the date cultures were obtained, organisms identified from culture results, and whether organisms were resistant to prescribed antibiotics. On 4/21/26 at 11:21 a.m., registered nurse (RN)-A , identified as the infection prevention nurse, stated antibiotic use was not tracked. RN-A stated the facility completed a log to monitor possible infections and confirmed antibiotic tracking was identified as a gap to ensure residents were on the correct antibiotic. RN-A stated follow-up of cultures and ensuring residents were prescribed the correct antibiotic was a gap and there was no current process for antibiotic stewardship. RN-A stated providers were responsible for reviewing and tracking culture results to ensure appropriate antibiotics were prescribed. RN-A confirmed the facility did not track antibiotic indications for use, dosage, duration, culture results, or whether antibiotics were discontinued timely. RN-A further stated if a resident had a urinary tract infection and a urine culture was obtained, the provider was expected to track and communicate results to the facility, and the facility did not have a process to ensure culture results were received or addressed. On 4/22/26 at 11:49 a.m., the interim director of nursing (DON) and RN-A verified infection surveillance related to antibiotic use and resistance was not tracked on the IPC log and confirmed the facility did not have a formal antibiotic stewardship process as expected. Facility Antibiotic Stewardship Program Policy and Procedure dated 1/26, indicated It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Director of Nursing – establish standards for nursing staff to assess, monitor and communicate changes in a resident's condition that could impact the need for antibiotics, use their influence as nurse leaders to help ensure antibiotics are prescribed only when appropriate, and educate front line nursing staff about the importance of antibiotic stewardship and explain policies in place to improve antibiotic use.			21375			06/12/2026

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21375	Continued from page 19 The Antibiotic Stewardship Program leaders utilize existing resources to support antibiotic stewards' efforts by working with the following partners: Infection Preventionist – utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms. Monitoring antibiotic use: Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated, or adjustments should be made (e.g., antibiotic time-out). Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. Monitor each monthly medication regimen review when the resident has been prescribed or is taking an antibiotic or any antibiotic regimen review as requested by the QAA committee. Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness (process measure). Antibiotic use shall be measured by (monthly prevalence, antibiotic starts, and/or antibiotic days of therapy). At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data.Nursing will monitor the initiation of antibiotics on residents and conduct an “antibiotic timeout” within 48-72 of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings. New or changed orders for antibiotics based on the		21375			06/12/2026	

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21375	Continued from page 20 antibiotic timeout recommendations will be obtained from the practitioner. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits could be taken to the QAPI (quality assurance and performance improvement) committee to ensure appropriate oversight and/or the need for continued monitoring. Time Period for Correction: Twenty-one (21) days.		21375			06/12/2026	
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) testing had been completed for 3 of 5 employees (cook (C)-A, nursing assistant (NA)-A, and registered nurse (RN)-A) at time of hire who were reviewed for TB control per Center for Disease Control and Prevention (CDC) recommendations. This had the potential to affect all 34 residents residing in the facility. Findings include:		21426	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: C-A: 2/18/26 was readministered the 2 step Mantoux on 5/15/2026 NA-A: 3/23/2026 was readministered the 2 step Mantoux on 5/15/2026 RN-A: 3/12/2026 was readministered the 2 step Mantoux on 5/15/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected An audit was completed on all active employees on 5/28/2026 by IP to ensure that all employees are compliant with tuberculosis testing procedures. Any found deficient to restart series. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was provided to the IP, DON, NHA, and HR on the Employee Tuberculosis Testing Policy on		06/12/2026	

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21426	Continued from page 21 Document review of the employee list dated 4/23/26, indicated the following hire dates: C-A: 2/18/26 NA-A: 3/23/26 RN-A: 3/12/26 Review of RN-A's Tuberculin Skin Test (TST) documentation dated 3/12/26, indicated first-step administration on 3/13/26, and results read on 3/15/26, and second-step administration on 3/23/26, with results read on 3/25/26. The documentation failed to include the times of administration and reading. Additionally, the record indicated RN-A self-administered both the first and second step TST and self-read the results, which is not consistent with acceptable clinical practice. Review of NA-A's TST documentation dated 3/23/26, indicated first-step administration on 3/23/26, with results read on 3/26/26 at 2:00 p.m., and second-step administration on 3/31/26, with results read on 4/1/26. The documentation lacked the times of administration for both steps and the time results were read on 4/1/26. Further review indicated the second-step results were read prior to the required 48–72-hour timeframe. Review of C-A's TST documentation dated 2/18/26 indicated first-step administration on 2/18/26 at 1:01 p.m. with results read on 2/20/26 at 8:30 a.m., which is less than 48 hours. Second-step administration was documented on 3/16/26, with results read on 3/19/26; however, the documentation lacked the time of administration, and the time results were read. On 4/22/26 at 9:29 a.m., RN-A, identified as the infection preventionist, stated the current process for TB testing and screening requires completion of the first TST prior to employees working directly with residents. RN-A confirmed the expectation that administration and result times should be documented and acknowledged the records did not include required times. RN-A further stated they were not aware that staff should not administer or read their own TST results and confirmed that TST results should not be read before 48 hours or after 72 hours. On 4/22/26 at 11:49 a.m., the director of nursing (DON) stated TB testing is expected to be completed in accordance with regulatory requirements.			21426	Continued from page 21 6/10/2026 by Director of Clinical Services All new hire files will be reviewed monthly x 3 months or until substantial compliance is obtained by HR and IP to ensure Employee Tuberculosis testing is completed per the requirements Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 6/15/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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21426	Continued from page 22 The facility Employee Tuberculosis Testing Policy dated 2024, indicated Follow State or local requirements regarding TB screening and testing of employees. In absence of state or local requirements follow CDC recommendations... All new staff shall receive 2 mantle TB skin tests given two weeks apart All initial and follow-up TB tests shall be administered and interpreted 48 -72 hours for skin tests by a trained health care provider on our staff or licensed physician no one may interpret his or own tests SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all residents and employees are screened and tested for TB disease. The DON or designee could develop a monitoring system by auditing to ensure ongoing compliance. The DON or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21426			06/12/2026	
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.		21530	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Pharmacy Recommendation Process management was assumed by the Director of Clinical Services on 4/22/2026 Interim DON was replaced on 5/18/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Pharmacy recommendations noted to be outstanding on in-house residents for past 90 days were completed by 6/2/2026 What measures will be put into place or what		06/12/2026	

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21530	Continued from page 23 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 document review, the facility failed to ensure consulting pharmacist recommendations were addressed or acted upon for 2 of 5 residents (R8, R28) reviewed for unnecessary medications. Findings include: R28's face sheet received on 4/23/26, included diagnoses of wedge compression fracture of lumbar vertebrae, hypertension, dependence on renal dialysis, hyperlipidemia (high levels of fat in the blood), depression, diabetes, congestive heart failure (heart not able to pump enough blood) and anemia. R28's quarterly Minimum Data Set (MDS) assessment dated 11/24/25, indicated her brief interview for mental status (BIMS) was 99, indicating the cognitive interview was not able to be completed. R28 had clear speech, could understand and be understood. Behaviors included rejection of care and verbal behaviors directed towards others. R28 was dependent upon staff for activities of daily living (ADLs) and didn't walk. R28's orders included 28 medications. R28's care plan identified diagnoses and problem areas with goals and interventions. Record review indicated monthly pharmacy reviews had been conducted from 6/13/25 through 4/21/26. Pharmacist recommendations were indicated for the following nine months: 6/13/25, 8/11/25, 10/13/25, 11/10/25, 12/5/25, plus waiting for response to previous recommendation, 1/10/26, 2/6/26, 3/9/26,			21530	Continued from page 23 systemic changes you will make to ensure that the deficient practice does not recur; and: Education was provided to DON on management of pharmacy recommendation system by Director of Clinical Services on 6/11/2026 Compliance with pharmacy recommendation follow up will be reviewed monthly by the registered pharmacist monthly and reported to QAPI Pharmacy Recommendations will be audited monthly x 3 months or until substantial compliance is obtained by the Director of Clinical Services to ensure recommendations are addressed appropriately Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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21530	Continued from page 24 plus waiting for response to previous recommendation, and 4/21/26. Requested copies of pharmacy recommendation with provider responses for each of the months. Of the nine months, only one recommendation with a provider response was provided for 10/13/25. R8's face sheet provided on 4/23/26, included diagnoses of Alzheimer's disease and dementia. R8's annual MDS assessment dated 2/25/26, indicated serve cognitive impairment, unclear speech, rarely/never understood and rarely/never understands. R8 was dependent upon staff for ADLs and did not walk. R8 was receiving hospice care. R8's orders included eight medications. R8's care plan identified diagnoses and problem areas with goals and interventions. Record review indicated monthly pharmacy reviews had been conducted from 6/13/25 through 4/21/26. Pharmacist recommendations were indicated for the following four months: 6/13/25, 9/11/25, 12/5/25, and 3/9/26. Requested copies of pharmacy recommendation with provider responses for each of the months and none were received. During an interview on 4/22/26 at 12:20 p.m., the regional clinical consultant (RCC)-D stated she did not believe they would find any more recommendations with provider responses than what had already been provided. The process was the responsibility of the interim director of nursing (DON). During a telephone interview on 4/22/26 at 12:30 p.m., the consultant pharmacist (CP)-E stated getting pharmacy recommendations with a provider response back from the facility was an ongoing issue. CP-E stated she had brought it up at QAPI (quality assurance and performance improvement) meetings and the medical director was aware. CP-E stated there had been a significant number of staff changes which likely contributed to the lack of sustained improvement. CP-E stated the interim DON informed her he would develop a process and create a binder, but CP-E had not seen that happen. During an interview on 4/23/26 at 11:36 p.m., the interim DON stated pharmacy sent the recommendations to him and he put them in the			21530			06/12/2026

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21530	Continued from page 25 provider folder at the desk for providers to review and sign. He believed the providers gave the recommendations to the nurses when complete and, “The nurses took care of them.” After that, the interim DON stated the forms were scanned into the electronic medical record (EMR). The interim DON admitted he did not follow through to ensure the recommendations were address by providers, implemented, and the completed forms scanned into the EMR. Regarding R28’s recommendations with provider responses, the interim DON stated he had looked for those and couldn’t find them. During a telephone interview on 4/23/26 at 11:38 a.m., the medical director (MD)-C stated pharmacy recommendation reports had been talked about at QAPI and in May 2025, the facility had created a new process to ensure compliance but it had not been sustained as a result of transitions in nursing leadership. Facility Medication Regime Policy dated 2024, indicated the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist and included a review of the resident's medical chart. The pharmacist communicated any irregularities to the facility in the following ways: 1) Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. 2) Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review and revise the process to ensure pharmacy consultant recommendations are acted upon in a timely manner and reports are maintained. The DON or designee could educate staff on the process. In addition, the DON or designee could determine a specific timeframe to conduct monitoring audits to ensure compliance. The DON or designee could take the results of the education and audits to the QAPI (quality assurance and performance improvement) committee to ensure appropriate oversight and/or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		21530			06/12/2026	
21931	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 31		21931	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:		06/12/2026	

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21931	Continued from page 26 Isolation and restraints. A minor patient who has been admitted to a residential program as defined in section 253C.01 has the right to be free from physical restraint and isolation except in emergency situations involving a likelihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, psychiatrist, or licensed psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from involuntary seclusion when the facility maintained locked exit doors that prevented residents from freely exiting the building, without conducting individualized assessments, clinical justification, or care planning to support the restriction. This deficient practice had the potential to affect 8 of 34 residents (R4, R6, R11, R16, R20, R7, R29, R39) residing at the facility. Findings include: R4's annual Minimum Data Set (MDS) assessment dated 4/3/26, indicated moderately impaired cognition, very important to go outside to get fresh air when the weather is good, no exhibited behaviors of wandering, utilized a motorized wheelchair independently. R4's care plan printed 4/22/26, indicated able to use powered wheelchair without any issue, able to wheel w/c (wheelchair) independently throughout and outside facility, independent for going in/out of facility backdoor to courtyard to smoke, not an elopement risk/wanderer, independent with transfers from bed/chair. R4's Elopement Risk Evaluation dated 2/17/26, indicated R4 was not at risk for elopement. R4's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R4's ability to leave the facility. R6's annual MDS assessment dated 3/22/26, indicated no cognitive impairment, no exhibited behaviors of wandering, very important to go outside to get fresh air when the weather is good,			21931	Continued from page 26 15 second egress was repaired by Maintenance Director on 5/19/2026 with posting indicating egress placed on the dining room door. 15 second egress was repaired by the Maintenance Director on 5/19/2026 on the main door with a posting indicating egress placed on that door. Egress posting was placed on the door at the east side of the building by the administrative offices. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents not at risk of elopement have the potential to be affected. A conversation was held with resident council president R7 on 5/22/2026 that the 15 second egress on all doors was repaired. Resident Council Resident R7 to relay that information during the next resident council meeting What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 5/28/2026 with facility staff by DON/Designee on the Abuse, Neglect, and Exploitation Policy, Resident Rights Policy, Elopements and Wandering Residents Policy, Accidents and Supervision Policy to include the 15 second egress on all exit doors. Any facility staff not receiving education by 6/11/2026 will not be allowed to work until education is completed Facility door checks will be conducted weekly to ensure that doors are functioning properly as part of regular facility maintenance and checks. Any doors found not to be functioning properly will be placed in TELS and repaired promptly. Describe the Quality Assurance and Process Improvement Program that will be put into place.		06/12/2026

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21931	Continued from page 27 independent with walking. R6's care plan printed on 4/22/26, indicated R6 enjoys walking, allowed to walk outside on grounds with notifying nursing staff, not an elopement risk/wanderer, walk independently. supervision assistance in corridors: ambulates without device, steady gait. R6's Elopement Risk Evaluation dated 4/13/26, indicated R6 was not at risk for elopement. R6's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting residents' ability to leave the facility. R11's quarterly MDS assessment dated 4/16/26, indicated intact cognition, no rejection of care, use of wheelchair, independent with transfers, independent with wheeling 150ft in wheelchair. R11's care plan revised 4/16/26, indicated resident is able to self-propel in wheelchair as well as walk with walker. R11's Elopement Risk Evaluation dated 12/30/25, indicated R11 was not at risk for elopement. R11's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R11's ability to leave the facility. R16's quarterly MDS assessment dated 2/1/26, no cognitive impairment, no exhibited behaviors of wandering, and utilized a motorized independently wheelchair. R16's care plan printed 4/22/26, indicated R16 was independent with mobility via use of his electric wheelchair, able to independently maneuver on and off the unit with his electric W/C, and not an elopement risk/wanderer. R16's Elopement Risk Evaluation dated 4/13/26, indicated R16 was not at risk for elopement. R16's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting residents' ability to leave the facility. R20's quarterly MDS assessment dated 4/22/26, indicated severely impaired cognition, no exhibited behaviors of wandering, utilized a manual wheelchair			21931	Continued from page 27 QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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21931	Continued from page 28 independently. R20's care plan printed 4/22/26, indicated occasionally uses front wheeled walker independently for ambulation in his room, locomotion: able to wheel himself independently in manual wheelchair, 1 assist prn (as needed), uses a w/c when outside of his room, independent for transferring, and not an elopement risk/wanderer. R20's Elopement Risk Evaluation dated 1/7/26, indicated R20 was not at risk for elopement. R20's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting residents' ability to leave the facility. R7's annual MDS assessment dated 2/25/26, indicated intact cognition, no behaviors, use of walker and wheelchair, independent with transfers and walking and propelling wheelchair. R7's care plan dated 4/19/24, indicated no risk for elopement, able to propel her own wheelchair to all location. R7's Elopement Risk Evaluation dated 11/24/25, indicated R7 was not at risk for elopement. R7's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R7's ability to leave the facility. R29's quarterly MDS assessment dated 4/7/26, indicated intact cognition, rejection of care one to three days, use of wheelchair, independent with transfers and propelling wheelchair. R29's care plan revised 4/7/26, indicated low risk for elopement, independent with transfers, okay to ambulate with four wheel walker (4WW) independently. R29's Elopement Risk Evaluation dated 3/14/26, indicated R29 was not at risk for elopement. R29's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R29's ability to leave the facility. R39's discharge return not anticipated Minimum Data Set (MDS) assessment dated 4/3/26, indicated intact cognition, no behaviors or wandering, no			21931			06/12/2026

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21931	Continued from page 29 rejection of care, wheelchair use, independent with wheeling with manual wheelchair, independent with transfers. R39's care plan printed 4/22/26, indicated indicated activities of daily living (ADL) self-care deficit related to paraplegia. The resident is able to: wheel self independently in manual wheelchair, low risk for elopement. R39's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R39's ability to leave the facility. On 4/21/26 at 8:30 a.m., the administrator stated the facility doors were locked from the outside and inside for safety and security, and that overrode resident rights. The administrator further stated it was her job to keep everyone safe, and no one was getting hurt or lost on her time. The administrator stated residents still had rights, staff could let them in and out and were always available. In addition, administrator stated residents were not told they were admitting to a locked building, and it was not in their admission packet that the building was locked from the inside. The administrator also stated there were some rules about when residents could go outside based on weather and time of day. The administrator stated residents at the facility were not committed by law to be in a locked facility, did not have a provider's order to be in a locked facility, and did not sign a consent to be in a locked facility. On 4/21/26 at 8:31 a.m., during further interview the administrator stated only staff had access to the codes to unlock the doors. The administrator confirmed residents, including those who were independent and without cognitive impairment, were unable to leave the building without requesting staff assistance. The administrator stated no individualized assessments, or waivers had been completed to support restricting residents' ability to leave without staff assistance. The administrator further confirmed residents had not been formally educated regarding the locked door system. On 4/21/26 at 12:49 p.m., activities aide (AA)-A stated all facility doors were locked and only staff possessed the code to open the doors, confirming residents could not independently leave through any door. On 4/21/26 at 12:52 p.m., R7 stated all doors were locked and only staff had access to the codes, and stated the doors were locked due to concerns about			21931			06/12/2026

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21931	Continued from page 30 other residents. On 4/21/26 at 12:52 p.m., health unit coordinator (HUC)-H stated all facility doors were locked from the inside and outside at all times and only staff had access to the codes. HUC-H stated the front door was expected to unlock after applying continuous pressure to the push bar for 15 seconds. During observation, the front door, which was constructed of solid wood with a keypad mounted on the adjacent wall, was pushed continuously for 15 seconds and did not unlock or release. HUC-Confirmed the door should have unlocked after sustained pressure. On 4/21/26 at 12:55 p.m., during a tour of the facility with maintenance director (MD)-A, the following was observed: On the north side of the building in the dining room an exit sign hung above a metal door with a glass upper panel and a horizontal push bar across the center. A keypad was mounted on the wall next to the door. The push bar was pressed continuously for approximately 30 seconds; however, the door remained locked and did not unlock or open. On the south side of the building, the main entrance door located in the day room area was a solid wood door with a keypad installed next to it and an exit sign above. The door remained locked and did not open without entering a code. On the east side of the building, near the administrative offices, there was a full glass, wide door with a metal push bar across the middle and a keypad mounted to the side. There were no visible instructions indicating how long to press the bar to unlock the door. When the push bar was pressed continuously for approximately 15 seconds, the locking mechanism disengaged, and the door unlocked. On the west side of the building in the activity room, there was a metal door with a glass upper panel, a horizontal push bar, a keypad mounted next to the door, and an exit sign posted above. The push bar was pressed continuously for approximately 30 seconds; however, the door did not unlock or open. On 4/21/26 at 1:07 p.m., MD-A stated the doors were intended to unlock after 15 seconds of continuous pressure on the push bar. MD-A confirmed that, except for the east side door, the doors did not function as intended. MD-A further stated the facility previously had a locked dementia			21931			06/12/2026

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21931	Continued from page 31 unit, which had been discontinued, and the door system had not been converted to allow unlocking after sustained pressure. MD-A stated the current configuration was consistent with a fully locked system rather than one designed to unlock after delay. On 4/21/26 at 1:11 p.m., during a telephone interview, the maintenance consultant confirmed the facility previously operated a locked unit requiring physician orders for placement and stated that when the unit was discontinued, the door system should have been changed to allow doors to unlock after sustained pressure. The consultant confirmed the current door function was not consistent with that expectation. On 4/21/26 at 9:33 a.m., R24 stated they walked without staff assistance and was independently able to perform self-cares, stated all doors were locked, required a code, and residents must ask permission to leave the building. R24 stated “almost like jail.” During an interview on 4/22/26 at 8:29 a.m., with the administrator and the regional clinical consultant (RCC)-D, the administrator who had been employed by the facility for two years, stated she didn't know how many years the doors had been locked from the inside, adding it had been that way since she started. The administrator stated she never looked at the doors as being locked, she looked at them as a security measure for residents to be safe from a variety of issues. Issues identified included the facility being located in a remote area, the steep bluff in front of the facility, farm fields around the facility, the opioid epidemic and potential drug seekers. Further, the administrator stated due to their isolation, they were a prime target for potential criminal activity. When that didn't fully explain the rationale for locking doors from the inside, the administrator stated staff were always available to let residents and visitors in and out of the facility, and that family members appreciated the safety the facility provided. The administrator stated they had never considered giving a passcode to residents who were independent and able to come and go freely for fear the code would be shared with others and/or a confused resident would follow a resident or visitor out the door. During the same interview, RCC-D stated the facility was small and staff were always available to let people out. RCC-D stated she did not believe the facility was treating residents as if they were in a secure unit and believed the intent of the regulation pertained to a unit, not a facility. RCC-D stated,			21931			06/12/2026

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21931	Continued from page 32 “This isn’t a specialty unit; we see it as a skilled facility where we are keeping residents safe,” adding, “We are not limiting the ability of residents to get out, we are ensuring we are providing adequate supervision.” The administrator stated, “We need to know who is outside, we worry about the cornfields as much as the ravines.” With regard to concerns expressed by R39 about being not being able to freely leave the facility when desired, the administrator stated R39 had been in a wheelchair and had not been able-bodied to leave the facility. The administrator stated the facility did not utilize a wander or elopement management system. On 4/23/26 at 8:41 a.m., during a telephone interview, the medical director stated they were not aware the facility doors were locked in a manner that prevented residents from independently leaving the building. The medical director stated they would expect to be informed if residents did not have the ability to leave the building freely. The medical director stated an individualized assessment should be completed for each resident, including evaluation of elopement risk, cognitive status, physical ability, and decision-making capacity, to determine whether the resident could safely leave the building independently or required supervision. The medical director stated if a resident did not demonstrate an elopement risk and had the ability to safely leave, the expectation would be that the resident could do so without restriction. The medical director further stated that if the facility restricted a resident’s ability to leave, there should be clear documentation supporting the rationale, including clinical assessment findings, care planning interventions, and, when appropriate, physician involvement or orders. The medical director stated the determination of safety versus resident rights must be individualized, and one generalized safety concern could not be applied to all residents. The medical director emphasized that without individualized assessment and supporting documentation, restricting all residents from leaving the building would not be appropriate. Facility policy on resident seclusion was requested. In an email dated 4/22/26 at 2:37 p.m., RCC-D indicated the facility did not have a policy on seclusion. Facility Resident Rights policy, dated 2025, indicated residents had the right to be treated with respect and dignity, including: the right to be free from any physical or chemical restraints imposed for			21931			06/12/2026

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21931	Continued from page 33 purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Residents had a right to a safe, clean, comfortable and homelike environment. Facility Accident and Supervision policy dated 2/2023, indicated the facility would establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. Process included: 1) Identification of Hazards and Risks - the process through which the facility became aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. 2) Evaluation and Analysis - the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. 3) Supervision was an intervention and a means of mitigating accident risk. The facility would provide adequate supervision to prevent accidents. Adequacy of supervision was defined by type and frequency and based on the individual resident's assessed needs and identified hazards in the resident environment. Facility Elopement and Wandering Residents policy dated 2024, indicated the facility ensured residents who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility was equipped with door locks/alarms to help avoid elopements. Alarms were not a replacement for necessary supervision. Staff were to be vigilant in responding to alarms in a timely manner. The facility would establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Facility Outdoor Safety policy dated 1/12/26, indicated it was the policy of the facility to provide a safe and healthy environment for residents. All residents were allowed and encouraged to enjoy outdoor activities if mentally and physically able to participate and weather conditions deemed safe. Residents were only allowed to participate in outside activities under specific conditions including the resident had been assessed to determine whether they were physically and cognitively safe to be out without supervision or whether they required		21931			06/12/2026	

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21931	Continued from page 34 supervision. If supervision was required, residents were to remain on the patio just outside the main entrance door or the enclosed area outside the activities office. If assessments indicated a resident was safe for outdoor activity independently, they must remain on sidewalks, patio, or enclosed area outside the activities office. SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing (DON) could review and revise policies and procedures related to the locked facility and provide education to prospective residents, current residents, and staff regarding the door system and ability to exit. In addition, the administrator or DON could obtain resident consent to be in the locked facility, provider orders for need to be in a locked facility, and ongoing individualized resident assessment of need. The administrator or DON could develop monitoring systems to ensure ongoing compliance and report those results to the Quality Assurance Performance Improvement (QAPI) committee for appropriate oversight and/or need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21931			06/12/2026

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E0000	Initial Comments On 4/20/26 to 4/23/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			05/22/2026	
F0000	INITIAL COMMENTS On 4/20/26 to 4/23/26, 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: NO deficiencies were cited. H52731515C (IQIES #2569283) H52731516C (IQIES #1142556) H52731517C (IQIES #1142562) H52731518C (IQIES #2622284) The following complaint was reviewed: An incidental finding was discovered and cited at (F603). H52731514C (iQIES #2624065) 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		F0000				

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

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

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F0000	Continued from page 1 of compliance.			F0000			05/22/2026
F0880 SS = F	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. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			F0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education provided to DON and IP on 6/3/2026 by Director of Clinical Services on the components of the Infection Prevention Program including maintaining a complete line listing, trending of infection and appropriate interventions to prevent further outbreaks to include employee illness line listing, tracking and trending of employee illnesses and their correlation to resident illnesses. Education and a copy of the Reportable List of Communicable Diseases to MDH were provided to DON and IP on 6/3/2026 by Director of Clinical Services Education was provided to the DON and IP on 6/3/2026 by the Director of Clinical Services on the Enhanced Barrier Precautions policy. Education was provided to the DON and IP on 6/3/2026 by Director of Clinical Services on the Antibiotic Stewardship Program. Education was provided to the DON and IP on 6/3/2026on completion of the annual Infection Risk Assessment and use of tool to create goals of the Infection Control and Prevention Program and reporting of goals and progress to QAPI monthly. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All Residents have the potential to be affected An audit was completed on 5/28/2026 by the IP on the infection and antibiotic log to ensure line listing was complete with signs and symptoms, any		06/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245273		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/23/2026	
NAME OF PROVIDER OR SUPPLIER Franklin Restorative Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 3RD STREET SOUTH , FRANKLIN, Minnesota, 55333			
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F0880 SS = F	Continued from page 2 (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 the infection prevention and control program included ongoing surveillance, analysis, and trending of resident and staff infections. Additionally, the facility failed to maintain knowledge of a current list of reportable communicable diseases, including when and to whom communicable diseases, healthcare-associated infections, and potential outbreaks must be reported. This had the potential to affect all 34 residents who resided in the facility. In addition, the facility failed to ensure adherence to enhanced barrier precautions (EBP) when nursing staff failed to wear personal protective equipment (gowns) when providing direct care to 2 of 2 residents (R4, R22) reviewed for pressure wounds. Findings include: INFECTION CONTROL PROGRAM/ COMMUNICABLE DISEASE LIST			F0880	Continued from page 2 laboratory tests including results, and antibiotic timeouts were completed with notification to MD as appropriate. Any entries found incomplete were updated. An audit was completed on 5/28/2026 by IP on all infections over the last 30 days with identified pathogens to ensure none met the standard of reporting to MDH. There were no reportable pathogens identified. The Infection Risk Assessment was completed on 5/28/2026 with goals identified and reported to QAPI at the 6/15/2026 meeting. An Audit was completed by the IP on all residents who meet the criteria for enhanced barrier precautions to ensure that orders are in place, care plan updated, sign on door to indicate resident is on enhanced barrier precautions, and appropriate PPE is readily available. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with licensed clinical staff on the Infection Prevention and Control Program and the Antibiotic Stewardship Program on 5/28/2026 by the DON/Designee with all licensed clinical staff to be educated by end of business day 6/11/2026. Any licensed clinical staff not receiving education by end of business day 6/11/2026 will not be allowed to work until being educated. Education was initiated with all clinical staff on 5/28/2026 by DON/Designee on the Enhanced Barrier Precaution policy. Any staff not receiving education by end of business day 6/11/2026 will not be allowed to work until being educated. New reports of infections of residents and staff will be reviewed Monday-Friday with any reports of infections from the weekend reviewed on Monday as part of the daily clinical standup to ensure that the line listing is complete and accurate, sign and symptoms are reported, antibiotic timeouts are completed for resident infections, and any infections on the Reportable List of Communicable Diseases		06/12/2026

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F0880 SS = F	Continued from page 3 Review of the Infection Surveillance Report dated 1/1/26–3/31/26 revealed documentation that included resident name, room number, infection onset date, signs and symptoms, status, and pharmacy orders. However, the report contained missing data related to signs and symptoms and lacked evidence of analysis of infections and illnesses, including identification of patterns or trends, implemented interventions, and required precautions. The facility was unable to provide documentation demonstrating analysis, trending, or evaluation of infection data. Review of the Employee Line List printed 4/22/26 included employee name, department, title, date, and symptoms. The documentation lacked evidence of analysis of infections or illnesses, including patterns or trends, interventions implemented, and precautions required. The facility did not provide evidence of trending or analysis of staff infection data. On 4/21/26 at 11:21 a.m., registered nurse (RN)-A, identified as the Infection Preventionist and employed at the facility for approximately one month, stated infections were tracked within the electronic medical record (EMR). RN-A reviewed EMR data for February and March 2026 and confirmed the data did not include comprehensive information such as signs and symptoms and primarily included infections associated with medication orders. RN-A confirmed gaps existed in the infection surveillance process and that some data was missing from tracking logs. RN-A further stated that monthly analysis of infections and illnesses is important to identify trends or patterns and to initiate interventions such as staff education and process improvements. RN-A also confirmed lack of awareness of a current list of reportable communicable diseases and was unable to describe the reporting protocol, including communication with local or state public health officials or identification of reportable outbreaks. On 4/22/26 at 11:49 a.m., the interim director of nursing (DON) and RN-A stated they were not aware of employee illness tracking processes. Both indicated that tracking employee illness would be important to identify symptoms and determine necessary precautions within the facility. The DON acknowledged the facility is expected to follow regulatory requirements related to infection surveillance. RN-A stated it is important for the infection preventionist to track employee illnesses to identify potential correlations with resident			F0880	Continued from page 3 are reported to MDH promptly. Line listings of residents and staff will be analyzed at least monthly for any trends in infections with a plan developed to prevent further outbreaks and reported to QAPI monthly. Antibiotic usage and timeouts will be analyzed at least monthly and reported to QAPI. Any trends in misuse of antibiotics will be addressed with providers as part of the QAPI process. Facility rounds will be conducted 3/week x 4 weeks, then twice weekly x 4 weeks, the weekly x 4 weeks or until substantial compliance is obtained to ensure all residents requiring enhanced barrier precautions have orders in place, care plan updated, signage on the door, and PPE easily accessible to staff. Audits will be completed on 5 staff interaction with residents requiring Enhanced Barrier Precautions 3/week x 4 weeks, then twice weekly x 4 weeks, the weekly x 4 weeks or until substantial compliance is obtained to ensure staff compliance with Enhanced Barrier Precautions requirements. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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F0880 SS = F	Continued from page 4 infections. On 4/22/26 at 12:32 p.m., the administrator stated the facility maintained a document tracking employee illnesses; however, the information had not been shared with RN-A and confirmed the data was not utilized for trending or analysis of staff infections. The facility Infection Prevention and Control Program Policy dated 3/5/25, indicated : Surveillance: A system of surveillance is utilized for prevention identifying reporting investigating and controlling infections and communicable diseases for all resident, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a civility assessment and accepted national standards. The infection preventionist serves as a leader in surveillance activities, maintains documentation of incidents, findings, and any other corrective actions made by the facility and report surveillance findings to the facilities quality assessment and assurance committee. The RNS and LPNS participate in surveillance through assessment of residents and reporting changes and conditions to the residents physicians and management staff per protocol for notification of changes and in-house reporting of communicable diseases and infections. EBP R4's face sheet provided on 4/22/26, included paraplegia (paralysis causing impairment of motor sensory function of lower extremities), pressure ulcers to right and left buttock and neuromuscular dysfunction of bladder (loss of bladder control due to disease or injury). R4's annual Minimum Data Set (MDS) assessment dated 2/18/26, indicated intact cognition, clear speech, could understand and be understood. Pressure ulcer to sacral region. Indwelling supra-pubic catheter (tube inserted into bladder through abdominal incision to drain urine). Independent with most activities of daily living. Mobility per motorized wheelchair.			F0880			06/12/2026

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F0880 SS = F	Continued from page 5 R4's provider orders included: 10/31/21: foley catheter 4/22/26: sacrum dressing: cleanse coccyx with wound cleanser. Place calcium alginate (absorbent dressing used primarily for managing exudate in wounds) in wound bed. Place barrier cream around peri-wound. Cover with ABD (abdominal pad) and tape down. Two times a day. No orders for enhanced barrier precautions (EBP). R4's care plan with revised date of 4/7/26, indicated R4 had a pressure injury stage 4 to coccyx, and that R4's pressure injuries would show signs of healing and remain free from infection by/through review date. Care plan dated 4/21/23, indicated R4 had an indwelling suprapubic catheter with history of chronic infections and had a history of ESBL (a bacteria) resistance in urine. The care plan did not indicate R4 had been in EBP. During an interview on 4/22/26 at 10:36 a.m., observed an EBP sign on R4's door. No cart outside the door containing personal protective equipment (PPE) including gowns. R4 had been lying in bed. When asked for permission to observe his dressing change, R4 stated he wanted to wait. Without asking, R4 stated, "Staff don't wear gowns when they empty my catheter or change my dressing – they never do." Observed two large, plastic, three-drawer organizers in R4's room and did not see any gowns. One tall, plastic doffing receptable was observed on top of one of the three-drawer organizers in the corner and hard to reach. Inside the receptable was one non-disposable blue gown. During an interview and observation on 4/23/26 at 8:50 a.m., when asked to observe his dressing change, R4 stated, "You won't see anything." When asked what he meant, stated staff will do what they are supposed to do – they will wear gowns. Again, looked around the room and did not see any PPE gowns. The receptable to doff reusable gowns still had only one blue gown in it for the past two days despite staff emptying urinary catheter bag each shift. In addition, the doffing receptable was still on top of the three-drawer supply bin and hard to reach, potentially indicating lack of use.			F0880			06/12/2026

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F0880 SS = F	Continued from page 6 During an interview and observation on 4/23/26 at 9:17 a.m., nursing assistant (NA)-B stated she was aware R4 was in EBP and stated she needed to wear PPE when she emptied R4's urine bag. NA-B could not recall the last time she emptied his bag. When asked where R4's PPE gowns were, NA-B stated they were in his room. Together went into R4's room. NA-B looked around and stated there were none. NA-B stated he was supposed to have a cart outside his room with gowns in it. When asked where staff put gowns when they take them off, NA-B pointed to the receptable on top of the three-drawer organizer and said that shouldn't be there. The receptable was removed and shown to NA-B who confirmed the cloth inside was one, blue reusable PPE gown. NA-B acknowledged there should have been more gowns in the receptable because staff emptied R4's urine bag every shift and changed his dressing every day. During an interview and observation on 4/23/26 at 9:44 a.m., together in R4's room, licensed practical nurse (LPN)-C was asked to locate the PPE gowns used for emptying R4's catheter and changing his dressing. LPN-C looked around the room and stated there were none, adding gowns and gloves should have been available outside R4's door. During an interview and observation on 4/23/26 at 10:02 a.m., together with RN-A who was also the infection preventionist, entered R4's room. RN-A verified R4 had been on EBP and verified a PPE cart had not been located outside of R4's door. RN-A stated residents in EBP should have a PPE cart outside their door and did not know what had happened to R4's. RN-A was asked to locate PPE gowns in the room and stated there were none. RN-A was asked if the doffing receptable was in an appropriate location and stated it was not. R4 who was lying in bed, informed RN-A staff never wore gowns to empty his urine or change his dressing. RN-A admitted to not noticing the lack of a PPE cart outside or R4's room and to not monitoring staff for adherence to EBP guidelines. During an observation on 4/23/2026 at 10:28 a.m., upon exiting R4's room, observed a PPE cart outside of R4's room and a doffing receptable just inside R4's room. Facility Enhanced Barrier Precautions policy with revised date of 3/5/25, indicated staff received training on EBP upon hire and annually, and were expected to comply with all designated precautions. An order for EBP would be obtained for residents with chronic wounds and urinary catheters. Gowns			F0880			06/12/2026

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F0880 SS = F	Continued from page 7 and gloves were immediately available near or outside of the residents room. PPE for EBP was only necessary when performing high-contact care activities. A trash can was to be positioned inside the room and near the exit to discard PPE after removal and prior to exit. The infection preventionist performed periodic monitoring of adherence to determine the need for additional training. High-contact resident care activities included wound care and device care including urinary catheters. R22's face sheet printed 4/22/26, indicated diagnoses of mild cognitive impairment, weakness, mood disorder, and excoriation skin-picking disorder. R22's annual MDS assessment dated 3/17/26, indicated intact cognition, no behaviors or rejection of care, use of wheelchair, dependent for personal hygiene and dressing, and no pressure ulcers, open lesions, or wounds. R22's physician's order dated 3/8/25, indicated weekly skin review on bath day every Sunday. R22's physician's order dated 3/20/26, indicated cleanse coccyx wound. Cover with foam dressing. Replace every other day. R22's care plan printed 4/22/26, indicated potential for impairment to skin integrity related to obesity with goal of maintaining intact skin by review date. Apply medications as directed when ordered for skin treatments. Keep skin clean and dry. Use lotion on dry skin. Do not use wet wipes. During interview on 4/20/26 at 3:09 p.m., R22 stated she had a pressure ulcer on her coccyx. R22 stated she did not recall staff wearing gowns when changing her brief or providing wound care. During observation and interview on 4/21/26 at 11:10 a.m., LPN-A completed R22's wound order. LPN-A removed R22's brief, cleansed her wound, and applied foam dressing. LPN-A did not wear a gown while completing wound care. LPN-A stated she was unsure if she needed to wear a gown while completing wound care for R22, and stated she did not see an enhanced barrier precautions (EBP) sign on R22's door or an EBP supply cart outside her room. LPN-A stated she would normally expect to wear a gown while completing a dressing change on a pressure ulcer. During observation on 4/21/26 at 3:15 p.m., R22's door had a new sign indicating EBP should be worn in her room when providing cares and had an EBP			F0880			06/12/2026

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F0880 SS = F	Continued from page 8 cart with gowns placed outside her door. During interview on 4/22/26 at 12:32 p.m., interim director of nursing (DON) stated he would expect EBP to be used for wounds that required a dressing to prevent spread of infection. Facility Enhanced Barrier Precautions policy with revised date of 3/5/25, indicated staff received training on EBP upon hire and annually, and were expected to comply with all designated precautions. An order for EBP would be obtained for residents with chronic wounds and urinary catheters. Gowns and gloves were immediately available near or outside of the residents room. PPE for EBP was only necessary when performing high-contact care activities. A trash can was to be positioned inside the room and near the exit to discard PPE after removal and prior to exit. The infection preventionist performed periodic monitoring of adherence to determine the need for additional training. High-contact resident care activities included wound care and device care including urinary catheters.			F0880			06/12/2026
F0881 SS = F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to implement and maintain an effective infection prevention and control program specific to antibiotic stewardship. The facility did not have a system to track antibiotic use, culture results, organisms identified, or antibiotic resistance to ensure residents received appropriate treatment, this had the ability to affect all 34 residents. Findings Include: Review of the Infection Prevention and Control (IPC) case list dated 1/1/26-3/31/26, , documentation included resident name, room number, onset date, signs and symptoms, current prescription,			F0881	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education provided to DON and IP on 6/3/2026 by Director of Clinical Services on the components of the Infection Prevention Program including maintaining a complete line listing, trending of infection and appropriate interventions to prevent further outbreaks to include employee illness line listing, tracking and trending of employee illnesses and their correlation to resident illnesses. Education and a copy of the Reportable List of Communicable Diseases to MDH were provided to DON and IP on 6/3/2026 by Director of Clinical Services Education was provided to the DON and IP on 6/3/2026 by the Director of Clinical Services on the Enhanced Barrier Precautions policy. Education was provided to the DON and IP on 6/3/2026 by Director of Clinical Services on the Antibiotic Stewardship Program. Education was provided to the DON and IP on		06/12/2026

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F0881 SS = F	Continued from page 9 prescriber, infection type, organism, diagnosis, and category. However, the log lacked documentation of the date cultures were obtained, organisms identified from culture results, and whether organisms were resistant to prescribed antibiotics. On 4/21/26 at 11:21 a.m., registered nurse (RN)-A , identified as the infection prevention nurse, stated antibiotic use was not tracked. RN-A stated the facility completed a log to monitor possible infections and confirmed antibiotic tracking was identified as a gap to ensure residents were on the correct antibiotic. RN-A stated follow-up of cultures and ensuring residents were prescribed the correct antibiotic was a gap and there was no current process for antibiotic stewardship. RN-A stated providers were responsible for reviewing and tracking culture results to ensure appropriate antibiotics were prescribed. RN-A confirmed the facility did not track antibiotic indications for use, dosage, duration, culture results, or whether antibiotics were discontinued timely. RN-A further stated if a resident had a urinary tract infection and a urine culture was obtained, the provider was expected to track and communicate results to the facility, and the facility did not have a process to ensure culture results were received or addressed. On 4/22/26 at 11:49 a.m., the interim director of nursing (DON) and RN-A verified infection surveillance related to antibiotic use and resistance was not tracked on the IPC log and confirmed the facility did not have a formal antibiotic stewardship process as expected. Facility Antibiotic Stewardship Program Policy and Procedure dated 1/26, indicated It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Director of Nursing – establish standards for nursing staff to assess, monitor and communicate changes in a resident's condition that could impact the need for antibiotics, use their influence as nurse leaders to help ensure antibiotics are prescribed only when appropriate, and educate front line nursing staff about the importance of antibiotic stewardship and explain policies in place to improve antibiotic use.			F0881	Continued from page 9 6/3/2026on completion of the annual Infection Risk Assessment and use of tool to create goals of the Infection Control and Prevention Program and reporting of goals and progress to QAPI monthly. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All Residents have the potential to be affected An audit was completed on 5/28/2026 by the IP on the infection and antibiotic log to ensure line listing was complete with signs and symptoms, any laboratory tests including results, and antibiotic timeouts were completed with notification to MD as appropriate. Any entries found incomplete were updated. An audit was completed on 5/28/2026 by IP on all infections over the last 30 days with identified pathogens to ensure none met the standard of reporting to MDH. There were no reportable pathogens identified. The Infection Risk Assessment was completed on 5/28/2026 with goals identified and reported to QAPI at the 6/15/2026 meeting. An Audit was completed by the IP on all residents who meet the criteria for enhanced barrier precautions to ensure that orders are in place, care plan updated, sign on door to indicate resident is on enhanced barrier precautions, and appropriate PPE is readily available. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with licensed clinical staff on the Infection Prevention and Control Program and the Antibiotic Stewardship Program on 5/28/2026 by the DON/Designee with all licensed clinical staff to be educated by end of business day 6/11/2026. Any licensed clinical staff not receiving education by end of business day 6/11/2026 will not be allowed to work until being educated.		06/12/2026

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F0881 SS = F	Continued from page 10 The Antibiotic Stewardship Program leaders utilize existing resources to support antibiotic stewards' efforts by working with the following partners: Infection Preventionist – utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms. Monitoring antibiotic use: Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated, or adjustments should be made (e.g., antibiotic time-out). Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. Monitor each monthly medication regimen review when the resident has been prescribed or is taking an antibiotic or any antibiotic regimen review as requested by the QAA committee. Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness (process measure). Antibiotic use shall be measured by (monthly prevalence, antibiotic starts, and/or antibiotic days of therapy). At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data.Nursing will monitor the initiation of antibiotics on residents and conduct an “antibiotic timeout” within 48-72 of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings.			F0881	Continued from page 10 Education was initiated with all clinical staff on 5/28/2026 by DON/Designee on the Enhanced Barrier Precaution policy. Any staff not receiving education by end of business day 6/11/2026 will not be allowed to work until being educated. New reports of infections of residents and staff will be reviewed Monday-Friday with any reports of infections from the weekend reviewed on Monday as part of the daily clinical standup to ensure that the line listing is complete and accurate, sign and symptoms are reported, antibiotic timeouts are completed for resident infections, and any infections on the Reportable List of Communicable Diseases are reported to MDH promptly. Line listings of residents and staff will be analyzed at least monthly for any trends in infections with a plan developed to prevent further outbreaks and reported to QAPI monthly. Antibiotic usage and timeouts will be analyzed at least monthly and reported to QAPI. Any trends in misuse of antibiotics will be addressed with providers as part of the QAPI process. Facility rounds will be conducted 3/week x 4 weeks, then twice weekly x 4 weeks, the weekly x 4 weeks or until substantial compliance is obtained to ensure all residents requiring enhanced barrier precautions have orders in place, care plan updated, signage on the door, and PPE easily accessible to staff. Audits will be completed on 5 staff interaction with residents requiring Enhanced Barrier Precautions 3/week x 4 weeks, then twice weekly x 4 weeks, the weekly x 4 weeks or until substantial compliance is obtained to ensure staff compliance with Enhanced Barrier Precautions requirements. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is		06/12/2026

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F0881 SS = F	Continued from page 11 New or changed orders for antibiotics based on the antibiotic timeout recommendations will be obtained from the practitioner.		F0881	Continued from page 11 maintained		06/12/2026	
F0603 SS = E	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from involuntary seclusion when the facility maintained locked exit doors that prevented residents from freely exiting the building, without conducting individualized assessments, clinical justification, or care planning to support the restriction. This deficient practice had the potential to affect 8 of 34 residents (R4, R6, R11, R16, R20, R7, R29, R39) residing at the facility. Findings include: R4's annual Minimum Data Set (MDS) assessment dated 4/3/26, indicated moderately impaired cognition, very important to go outside to get fresh air when the weather is good, no exhibited behaviors of wandering, utilized a motorized wheelchair independently. R4's care plan printed 4/22/26, indicated able to use powered wheelchair without any issue, able to wheel w/c (wheelchair) independently throughout and outside facility, independent for going in/out of facility backdoor to courtyard to smoke, not an elopement risk/wanderer, independent with transfers		F0603	Facility alleges substantial compliance on 6/12/2026 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 15 second egress was repaired by Maintenance Director on 5/19/2026 with posting indicating egress placed on the dining room door. 15 second egress was repaired by the Maintenance Director on 5/19/2026 on the main door with a posting indicating egress placed on that door. Egress posting was placed on the door at the east side of the building by the administrative offices. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents not at risk of elopement have the potential to be affected. A conversation was held with resident council president R7 on 5/22/2026 that the 15 second egress on all doors was repaired. Resident Council Resident R7 to relay that information during the next resident council meeting Letter was given to residents to explain that the 15 second egress on doors were repaired on 5/29/2026 A message was sent on the facility communication platform to responsible parties of residents on 5/29/2026 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated on 5/28/2026 with facility staff by DON/Designee on the Abuse, Neglect, and		06/12/2026	

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F0603 SS = E	Continued from page 12 from bed/chair. R4's Elopement Risk Evaluation dated 2/17/26, indicated R4 was not at risk for elopement. R4's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R4's ability to leave the facility. R6's annual MDS assessment dated 3/22/26, indicated no cognitive impairment, no exhibited behaviors of wandering, very important to go outside to get fresh air when the weather is good, independent with walking. R6's care plan printed on 4/22/26, indicated R6 enjoys walking, allowed to walk outside on grounds with notifying nursing staff, not an elopement risk/wanderer, walk independently. supervision assistance in corridors: ambulates without device, steady gait. R6's Elopement Risk Evaluation dated 4/13/26, indicated R6 was not at risk for elopement. R6's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting residents' ability to leave the facility. R11's quarterly MDS assessment dated 4/16/26, indicated intact cognition, no rejection of care, use of wheelchair, independent with transfers, independent with wheeling 150ft in wheelchair. R11's care plan revised 4/16/26, indicated resident is able to self-propel in wheelchair as well as walk with walker. R11's Elopement Risk Evaluation dated 12/30/25, indicated R11 was not at risk for elopement. R11's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R11's ability to leave the facility. R16's quarterly MDS assessment dated 2/1/26, no cognitive impairment, no exhibited behaviors of wandering, and utilized a motorized independently wheelchair. R16's care plan printed 4/22/26, indicated R16 was independent with mobility via use of his electric wheelchair, able to independently maneuver on and			F0603	Continued from page 12 Exploitation Policy, Resident Rights Policy, Elopements and Wandering Residents Policy, Accidents and Supervision Policy to include the 15 second egress on all exit doors. Any facility staff not receiving education by 6/11/2026 will not be allowed to work until education is completed Facility door checks will be conducted weekly to ensure that doors are functioning properly as part of regular facility maintenance and checks. Any doors found not to be functioning properly will be placed in TELS and repaired promptly. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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F0603 SS = E	Continued from page 13 off the unit with his electric W/C, and not an elopement risk/wanderer. R16's Elopement Risk Evaluation dated 4/13/26, indicated R16 was not at risk for elopement. R16's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting residents' ability to leave the facility. R20's quarterly MDS assessment dated 4/22/26, indicated severely impaired cognition, no exhibited behaviors of wandering, utilized a manual wheelchair independently. R20's care plan printed 4/22/26, indicated occasionally uses front wheeled walker independently for ambulation in his room, locomotion: able to wheel himself independently in manual wheelchair, 1 assist prn (as needed), uses a w/c when outside of his room, independent for transferring, and not an elopement risk/wanderer. R20's Elopement Risk Evaluation dated 1/7/26, indicated R20 was not at risk for elopement. R20's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting residents' ability to leave the facility. R7's annual MDS assessment dated 2/25/26, indicated intact cognition, no behaviors, use of walker and wheelchair, independent with transfers and walking and propelling wheelchair. R7's care plan dated 4/19/24, indicated no risk for elopement, able to propel her own wheelchair to all location. R7's Elopement Risk Evaluation dated 11/24/25, indicated R7 was not at risk for elopement. R7's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R7's ability to leave the facility. R29's quarterly MDS assessment dated 4/7/26, indicated intact cognition, rejection of care one to three days, use of wheelchair, independent with transfers and propelling wheelchair. R29's care plan revised 4/7/26, indicated low risk for elopement, independent with transfers, okay to			F0603			06/12/2026

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F0603 SS = E	Continued from page 14 ambulate with four wheel walker (4WW) independently. R29's Elopement Risk Evaluation dated 3/14/26, indicated R29 was not at risk for elopement. R29's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R29's ability to leave the facility. R39's discharge return not anticipated Minimum Data Set (MDS) assessment dated 4/3/26, indicated intact cognition, no behaviors or wandering, no rejection of care, wheelchair use, independent with wheeling with manual wheelchair, independent with transfers. R39's care plan printed 4/22/26, indicated indicated activities of daily living (ADL) self-care deficit related to paraplegia. The resident is able to: wheel self independently in manual wheelchair, low risk for elopement. R39's record review revealed no evidence of individualized assessments, care plans, physician orders, or clinical justification to support restricting R39's ability to leave the facility. On 4/21/26 at 8:30 a.m., the administrator stated the facility doors were locked from the outside and inside for safety and security, and that overrode resident rights. The administrator further stated it was her job to keep everyone safe, and no one was getting hurt or lost on her time. The administrator stated residents still had rights, staff could let them in and out and were always available. In addition, administrator stated residents were not told they were admitting to a locked building, and it was not in their admission packet that the building was locked from the inside. The administrator also stated there were some rules about when residents could go outside based on weather and time of day. The administrator stated residents at the facility were not committed by law to be in a locked facility, did not have a provider's order to be in a locked facility, and did not sign a consent to be in a locked facility. On 4/21/26 at 8:31 a.m., during further interview the administrator stated only staff had access to the codes to unlock the doors. The administrator confirmed residents, including those who were independent and without cognitive impairment, were unable to leave the building without requesting staff assistance. The administrator stated no individualized assessments, or waivers had been			F0603			06/12/2026

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F0603 SS = E	Continued from page 15 completed to support restricting residents' ability to leave without staff assistance. The administrator further confirmed residents had not been formally educated regarding the locked door system. On 4/21/26 at 12:49 p.m., activities aide (AA)-A stated all facility doors were locked and only staff possessed the code to open the doors, confirming residents could not independently leave through any door. On 4/21/26 at 12:52 p.m., R7 stated all doors were locked and only staff had access to the codes, and stated the doors were locked due to concerns about other residents. On 4/21/26 at 12:52 p.m., health unit coordinator (HUC)-H stated all facility doors were locked from the inside and outside at all times and only staff had access to the codes. HUC-H stated the front door was expected to unlock after applying continuous pressure to the push bar for 15 seconds. During observation, the front door, which was constructed of solid wood with a keypad mounted on the adjacent wall, was pushed continuously for 15 seconds and did not unlock or release. HUC-Confirmed the door should have unlocked after sustained pressure. On 4/21/26 at 12:55 p.m., during a tour of the facility with maintenance director (MD)-A, the following was observed: On the north side of the building in the dining room an exit sign hung above a metal door with a glass upper panel and a horizontal push bar across the center. A keypad was mounted on the wall next to the door. The push bar was pressed continuously for approximately 30 seconds; however, the door remained locked and did not unlock or open. On the south side of the building, the main entrance door located in the day room area was a solid wood door with a keypad installed next to it and an exit sign above. The door remained locked and did not open without entering a code. On the east side of the building, near the administrative offices, there was a full glass, wide door with a metal push bar across the middle and a keypad mounted to the side. There were no visible instructions indicating how long to press the bar to			F0603			06/12/2026

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F0603 SS = E	Continued from page 16 unlock the door. When the push bar was pressed continuously for approximately 15 seconds, the locking mechanism disengaged, and the door unlocked. On the west side of the building in the activity room, there was a metal door with a glass upper panel, a horizontal push bar, a keypad mounted next to the door, and an exit sign posted above. The push bar was pressed continuously for approximately 30 seconds; however, the door did not unlock or open. On 4/21/26 at 1:07 p.m., MD-A stated the doors were intended to unlock after 15 seconds of continuous pressure on the push bar. MD-A confirmed that, except for the east side door, the doors did not function as intended. MD-A further stated the facility previously had a locked dementia unit, which had been discontinued, and the door system had not been converted to allow unlocking after sustained pressure. MD-A stated the current configuration was consistent with a fully locked system rather than one designed to unlock after delay. On 4/21/26 at 1:11 p.m., during a telephone interview, the maintenance consultant confirmed the facility previously operated a locked unit requiring physician orders for placement and stated that when the unit was discontinued, the door system should have been changed to allow doors to unlock after sustained pressure. The consultant confirmed the current door function was not consistent with that expectation. On 4/21/26 at 9:33 a.m., R24 stated they walked without staff assistance and was independently able to perform self-cares, stated all doors were locked, required a code, and residents must ask permission to leave the building. R24 stated “almost like jail.” During an interview on 4/22/26 at 8:29 a.m., with the administrator and the regional clinical consultant (RCC)-D, the administrator who had been employed by the facility for two years, stated she didn’t know how many years the doors had been locked from the inside, adding it had been that way since she started. The administrator stated she never looked at the doors as being locked, she looked at them as a security measure for residents to be safe from a variety of issues. Issues identified included the facility being located in a remote area, the steep bluff in front of the facility, farm fields around the			F0603			06/12/2026

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F0603 SS = E	Continued from page 17 facility, the opioid epidemic and potential drug seekers. Further, the administrator stated due to their isolation, they were a prime target for potential criminal activity. When that didn't fully explain the rationale for locking doors from the inside, the administrator stated staff were always available to let residents and visitors in and out of the facility, and that family members appreciated the safety the facility provided. The administrator stated they had never considered giving a passcode to residents who were independent and able to come and go freely for fear the code would be shared with others and/or a confused resident would follow a resident or visitor out the door. During the same interview, RCC-D stated the facility was small and staff were always available to let people out. RCC-D stated she did not believe the facility was treating residents as if they were in a secure unit and believed the intent of the regulation pertained to a unit, not a facility. RCC-D stated, "This isn't a specialty unit; we see it as a skilled facility where we are keeping residents safe," adding, "We are not limiting the ability of residents to get out, we are ensuring we are providing adequate supervision." The administrator stated, "We need to know who is outside, we worry about the cornfields as much as the ravines." With regard to concerns expressed by R39 about being not being able to freely leave the facility when desired, the administrator stated R39 had been in a wheelchair and had not been able-bodied to leave the facility. The administrator stated the facility did not utilize a wander or elopement management system. On 4/23/26 at 8:41 a.m., during a telephone interview, the medical director stated they were not aware the facility doors were locked in a manner that prevented residents from independently leaving the building. The medical director stated they would expect to be informed if residents did not have the ability to leave the building freely. The medical director stated an individualized assessment should be completed for each resident, including evaluation of elopement risk, cognitive status, physical ability, and decision-making capacity, to determine whether the resident could safely leave the building independently or required supervision. The medical director stated if a resident did not demonstrate an elopement risk and had the ability to safely leave, the expectation would be that the resident could do so without restriction. The medical director further stated that if the facility restricted a resident's ability to leave, there should be clear documentation			F0603			06/12/2026

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F0603 SS = E	Continued from page 18 supporting the rationale, including clinical assessment findings, care planning interventions, and, when appropriate, physician involvement or orders. The medical director stated the determination of safety versus resident rights must be individualized, and one generalized safety concern could not be applied to all residents. The medical director emphasized that without individualized assessment and supporting documentation, restricting all residents from leaving the building would not be appropriate. Facility policy on resident seclusion was requested. In an email dated 4/22/26 at 2:37 p.m., RCC-D indicated the facility did not have a policy on seclusion. Facility Resident Rights policy, dated 2025, indicated residents had the right to be treated with respect and dignity, including: the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Residents had a right to a safe, clean, comfortable and homelike environment. Facility Accident and Supervision policy dated 2/2023, indicated the facility would establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. Process included: 1) Identification of Hazards and Risks - the process through which the facility became aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. 2) Evaluation and Analysis - the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. 3) Supervision was an intervention and a means of mitigating accident risk. The facility would provide adequate supervision to prevent accidents. Adequacy of supervision was defined by type and frequency and based on the individual resident's assessed needs and identified hazards in the resident environment. Facility Elopement and Wandering Residents policy dated 2024, indicated the facility ensured residents who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility was equipped with door locks/alarms to help avoid elopements. Alarms were			F0603			06/12/2026

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F0603 SS = E	Continued from page 19 not a replacement for necessary supervision. Staff were to be vigilant in responding to alarms in a timely manner. The facility would establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Facility Outdoor Safety policy dated 1/12/26, indicated it was the policy of the facility to provide a safe and healthy environment for residents. All residents were allowed and encouraged to enjoy outdoor activities if mentally and physically able to participate and weather conditions deemed safe. Residents were only allowed to participate in outside activities under specific conditions including the resident had been assessed to determine whether they were physically and cognitively safe to be out without supervision or whether they required supervision. If supervision was required, residents were to remain on the patio just outside the main entrance door or the enclosed area outside the activities office. If assessments indicated a resident was safe for outdoor activity independently, they must remain on sidewalks, patio, or enclosed area outside the activities office.		F0603			06/12/2026	
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.		F0641	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R11 MDS was modified on 3/31/2026 by MDS coordinator R29 MDS dated was modified on 3/31/2026 by MDS coordinator Education was provided to the MDS coordinator on 5/21/2026 by the Director of Clinical Reimbursement on the Conducting and Accurate Resident Assessment Policy. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents taking Aspirin have the potential to be affected		06/12/2026	

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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
F0641 SS = D	Continued from page 20 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure medications were coded accurately on the Minimum Data Set (MDS) assessments for 2 of 5 residents (R11 and R29) reviewed for unnecessary medications. Findings include: R11's face sheet printed 4/22/26, indicated diagnoses of type two diabetes with complications, alcohol abuse, and weakness. R11's quarterly MDS dated 4/16/26, indicated intact cognition, no rejection of care, use of wheelchair, independent with dressing and hygiene, and section N identified R11 took an anticoagulant. R11's physician's orders printed 4/22/26, did not include an anticoagulant but did include and order for aspirin oral capsule 81mg by mouth one time a day. R11's care plan revised 4/16/26, did not include mention of an anticoagulant medication. R29's face sheet printed 4/22/26, indicated diagnoses of chronic respiratory failure, repeated falls, and systolic heart failure. R29's quarterly MDS dated 4/7/26, indicated intact cognition, rejection of care one to three days, use of wheelchair, partial assistance with hygiene, substantial assistance with lower body dressing, and section N identified R29 took an anticoagulant. R29's physician's orders printed 4/22/26, included an order for aspirin oral tablet delayed release 81mg	F0641	Continued from page 20 An audit of residents coded to be on an anticoagulant was completed on 3/31/2026 by Director of Clinical Reimbursement to ensure all were coded correctly What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Duties of the in-house MDS coordinator were adjusted that she would no longer be completing the MDS on 6/1/2026 MDS to be completed by remote MDS coordinator who holds a certification on completion of the MDS on 6/1/2026 to ensure accuracy of assessments completed going forward. An Audit will be conducted on 1 MDS weekly x 8 weeks to ensure accuracy of coding by MDS coordinator. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026	06/12/2026

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F0641 SS = D	Continued from page 21 by mouth one time a day, but did not include an order for an anticoagulant medication. R29's care plan revised 4/7/26, did not include mention of an anticoagulant medication. During interview on 4/21/26 at 9:29 a.m., registered nurse (RN)-A stated she thought the aspiri taken by both R11 and R29 could be counted as an anticoagulant medication on the MDS assessment. RN-A stated she would clarify with the person who trained her. After clarification, RN-A stated aspirin should be coded as an antiplatelet medication, not an anticoagulant medication. RN-A further stated the MDS was coded incorrectly and she would submit corrections. During interview on 4/22/25 at 2:08 p.m., interim director of nursing stated he would expect the MDS to be coded correctly based on the resident assessment instrument (RAI) directions to ensure accurate representation of resident needs. Facility Conducting an Accurate Resident Assessment policy dated 1/2026, stated accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status using the appropriate RAI instructions.			F0641			06/12/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to report elevated blood glucose levels per provider order for 1 of 1 residents (R5) reviewed for insulin. In addition, the facility failed to calibrate blood glucose monitors according to manufacturer instructions for 1 of 1 residents (R5) reviewed for insulin. Further, the facility failed to			F0684	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R5 blood glucose readings and current orders were reviewed with MD on 5/22/2026 Blood Glucose machines were calibrated on 5/26/2026 per manufacturer guidelines Order to monitor skin for s/s of infection r/t skin picking initiated for R22 on 4/29/2026 Skin check completed on R22 on 5/12/2026 indicates no skin issues. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:		06/12/2026

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F0684 SS = D	Continued from page 22 ensure monitoring of skin wounds for 1 of 1 resident (R22) reviewed for non-pressure skin conditions. Findings include: ELEVATED BLOOD GLUCOSE AND CALIBRATION OF MONITOR R5's face sheet received on 4/22/26, included diagnoses of diabetes with hyperglycemia (elevated blood sugar). R5's annual Minimum Data Set (MDS) assessment dated 2/6/26, indicated intact cognition, clear speech, could understand and be understood. R5 was independent with most activities of daily living, did not walk and could propel wheelchair independently. R5's provider order dated 7/31/25, indicated blood sugar checks two times a day. Order dated 6/21/21, indicated staff were to notify provider if BS (blood sugar) was <70 or >400. R5's care plan dated 8/16/21, indicated R5 had diabetes and his blood sugars would remain within normal limits through next review. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Review of R5's electronic medical record (EMR) indicated in March and April 2026, two of R5's fingerstick blood sugars had been in excess of 400 mg (milligram)/dl (deciliter) without documentation that a provider had been notified. On 3/31/26 at 9:00 a.m., blood sugar had been 536 mg/dl On 4/3/26 at 4:40 p.m., blood sugar had been 421 mg/dl A provider note dated 3/17/26, (prior to documentation of the elevated blood sugars) indicated R5 had presented for evaluation of type 2 diabetes. Recent A1c (blood test that measures average blood sugar levels over the past two or three months) was 8.8% (normal = 5.7%). Minor adjustments to diabetes medications had been made and R5 would continue to be monitored closely. During an interview on 4/23/26 at 10:30 a.m., regional clinical consultant (RCC)-D looked in R5's			F0684	Continued from page 22 All residents who are diabetic have the potential to be affected. All residents with wounds have the potential to be affected Blood glucose readings for past 30 days audited with high readings reviewed by NP on 5/26/2026 A full house skin sweep was completed on in-house residents on 5/15/2026 with any residents found to have wounds or open areas referred to wound care for evaluation and appropriate monitoring initiated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with Licensed clinical staff on 5/26/2026 on Notification of Changes Policy, Skin Assessment Policy, Blood Glucose Monitoring Policy with all licensed clinical staff being educated by 6/11/2026. Any licensed clinical staff not receiving education by 5/11/2026 will not be allowed to work until receiving education. Audit will be completed 3/week x 4 weeks, then 2/week x 4 weeks, then weekly x 4 weeks or until substantial compliance is maintained to ensure blood glucose quality control checks are completed per policy. Blood Glucose out of range will be reviewed daily Monday – Friday as part of the daily clinical standup process with elevated blood glucose readings over the weekend reviewed on Monday to ensure appropriate notifications are made and follow up completed. Immediate education up to and including corrective action will be provided to nurses failing to do proper notifications. Audit will be completed 3/week x 4 weeks, then 2/week x 4 weeks, then 1/week x 4 weeks on 5 random residents weekly skin check to ensure appropriate monitoring and interventions are initiated for any newly identified areas.		06/12/2026

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F0684 SS = D	Continued from page 23 EMR and verified the two blood sugars greater than 400 mg/dl. RCC-D also verified there had not been an order for a sliding scale (where insulin dosages were adjusted based on blood sugar levels), nor had there been documentation nursing staff notified a provider of the blood sugars greater than 400 mg/dl. RCC-D stated she would have expected nursing staff to follow provider orders, inform the provider of the elevated blood sugars and potentially receive new orders. Further, RCC-D was informed nursing staff did not know if glucometers were being calibrated per manufacturer instructions, something that would be considered with abnormally high blood sugars checks. RCC-D stated she would expect glucometers to be calibrated and would check on it. At 10:41 a.m., RCC-D stated she could not see evidence glucometers where being calibrated. During an interview on 4/23/26 at 10:45 a.m., trained medication aide (TMA)-A stated she did not know anything about glucometer calibration. During an interview on 4/23/26 at 12:10 a.m., licensed practical nurse (LPN)-B who had earlier stated she did not think glucometers were calibrated, obtained R5's glucometer from the medication cart and the brand was Arkray Assure Platinum. Together with LPN-B, looked in medication room for evidence glucometers had been calibrated. LPN-B found unopened boxes of control solutions with expiration dates of 2027, but no binder or other documentation that indicated calibration was being done. During a telephone interview on 4/23/26 at 3:13 p.m., licensed practical nurse (LPN)-A recalled R5's blood sugar greater than 500 mg/dl at the end of March. LPN-A admitted she did not call the provider to notify him, but may have sent the provider an electronic message, however, could not say for certain. LPN-A acknowledged the importance of following provider orders and notifying a provider with a significantly elevated blood sugar to allow the provider to make medication adjustments if necessary. During a telephone interview on 4/23/26 at 3:48 p.m., advanced practice registered nurse (APRN)-F did not recall being informed of R5's elevated blood sugars greater than 400 mg/dl in March and April. APRN-F stated the reason it was good to be notified for anything over 400 mg/dl was so action could be taken, such as a one-time dose of insulin. Informed there had been an order to inform the provider of blood sugars great than 400 mg/dl – he was not aware of that and stated he would expect nursing staff to follow provider orders and/or facility policy.			F0684	Continued from page 23 Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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F0684 SS = D	Continued from page 24 Facility Blood Glucose Monitoring policy dated 2023, indicated the facility would perform blood glucose monitoring as per physician's orders and report critical test results to the physician timely. Calibration checks on glucometers must be performed _____ (this space was left blank) as per manufacturer's instructions. Manufacturer Instructions: The Quality Assurance/Quality Control Reference Manual with revised date of 10/24, found on website (Assure Platinum® Blood Glucose Meter - ARKRAY USA, Inc.) for the Arkray Assure Platinum glucometer, indicated, the user should check meter and test strips using Assure® Dose Control Solutions (Normal-Level 1 and High-Level 2) to confirm the meter and test strips are working properly, or to check if testing correctly. Assure Dose Control Solutions contain known amounts of glucose and are used to check that the meter and the test strips are working properly. The test strip bottles have Assure Dose Control Solution ranges printed on the labels. Compare the result displayed on the meter to the Assure Dose Control Solution range printed on the test strip bottle. Before using a new meter or a new bottle of test strips, conduct a control solution test following the procedure with two different levels of control solutions (Normal-Level 1 and High-Level 2). USE CONTROL SOLUTION • To test technique. • Before testing with the meter for the first time. • When opening a new bottle of test strips. • When suspecting the meter or test strips may not be functioning properly. • If the test results appear to be abnormally high or low or are not consistent with clinical symptoms. • When the meter has been dropped or stored below 32°F (0°C) or above 122°F (50°C). • The test strip bottle has been left open or has been exposed to light, temperatures below 39°F (4°C) or above 86°F (30°C), or humidity levels above 80%. • Each time the batteries are changed. NON-PRESSURE SKIN CONDITION R22's face sheet printed 4/22/26, indicated diagnoses of mild cognitive impairment, weakness, mood disorder, and excoriation skin-picking disorder. R22's annual MDS assessment dated 3/17/26, indicated intact cognition, no behaviors or rejection of care, use of wheelchair, dependent for personal hygiene and dressing, and no pressure ulcers, open lesions, or wounds.			F0684			06/12/2026

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F0684 SS = D	Continued from page 25 R22's physician's order dated 3/8/25, indicated weekly skin review on bath day every Sunday. R22's care plan printed 4/22/26, indicated potential for impairment to skin integrity related to obesity with goal of maintaining intact skin by review date. Apply medications as directed when ordered for skin treatments. Keep skin clean and dry. Use lotion on dry skin. Do not use wet wipes. During observation and interview on 4/20/26 at 3:11 p.m., R22 was awake in her bed. R22 had four small scabs (0.1cm to 0.4cm) and 3 scabs (0.3cm to 0.6cm) on her left arm. R22 had one larger scab (0.7cm) on her right arm that she was actively picking open. R22 stated nurses did not check on her scabs, put medication on them, or ask her what they were from. R22 stated she always had scabs. R22's weekly bath audits dated 4/5/26 and 4/12/26, indicated no skin alterations or open areas, other than wound to coccyx. During interview on 4/22/26 at 11:59 a.m., TMA-B stated she was aware of R22's skin-picking and her multiple scabs. TMA-B stated she thought they used to monitor the scabs and document it on the treatment record, but they no longer did that. TMA-B stated they used to use a cream on her scabs but she didn't see that ordered anymore either. TMA-B stated those areas would normally be documented and monitored on weekly bath audits but she did not see them documented for R22. During interview on 4/22/26 at 12:07 p.m., LPN-C stated R22 had a bath on 4/19/26, and she didn't see that R22's scabs were documented or assessed at that time. LPN-C stated she did not see any monitoring or treatment for R22's scabs on her physician's orders. During interview on 4/22/26 at 12:32 p.m., interim director of nursing (DON) stated he was aware of R22's skin-picking diagnosis but was not sure if they were monitoring or treating her scabs. DON stated he didn't think they were doing anything for the scabs. DON stated if R22 had wounds from skin-picking he would expect them to be monitored for signs of infection and worsening to prevent future injury or illness for R22. Facility Skin Assessment policy printed 4/22/26, indicated a full body skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for three, and weekly			F0684			06/12/2026

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F0684 SS = D	Continued from page 26 thereafter. Documentation of skin assessment: document observation, types of wounds, other information as indicated.			F0684			06/12/2026
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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to follow provider orders for wound care dressing changes for 1 of 1 resident (R4) reviewed for pressure injury. Findings include: R4's face sheet provided on 4/22/26, included diagnoses of paraplegia (paralysis causing impairment of motor sensory function of lower extremities) and pressure ulcers to right and left buttock. R4's annual Minimum Data Set (MDS) assessment dated 2/18/26, indicated intact cognition, clear speech, could understand and be understood. No behaviors. Pressure ulcer to sacral region. Independent with most activities of daily living. Mobility per motorized wheelchair. R4's provider orders dated 4/22/26, indicated: sacrum dressing: cleanse coccyx with wound cleanser. Place calcium alginate (absorbent dressing used primarily for managing exudate in wounds) in wound bed. Place barrier cream around peri-wound. Cover with ABD (abdominal pad) and tape down. Two times a day, start 4/22/26.			F0686	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: R4 was evaluated by wound care practitioner on 5/18/2026 with treatment orders updated. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents with wounds have the potential to be affected An audit was conducted on the TARS of all residents with wounds for missed documentation of wound care on 5/28/2026 with education provided to nurses failing to document completion of wound care. Skin Sweep was completed on all in-house residents on 5/15/2026 with any residents found to have wounds or open areas referred to wound care for evaluation and appropriate treatment orders updated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was initiated with licensed clinical staff on Wound Treatment Management Policy and Documentation of Wound Treatments Policy by DON/Designee on 5/26/2026 with all licensed clinical staff receiving education by 6/11/2026. Any licensed clinical staff not receiving education by 6/11/2026 will not be allowed to work until education is received. Audits will be completed on the TARS of residents with wounds will be completed 3/week x 4 weeks, then 2/week x 4 weeks, then 1/week x 4 weeks or until substantial compliance is obtained. Immediate education up to and including corrective action to nurses failing to document wound care		06/12/2026

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F0686 SS = D	Continued from page 27 R4's care plan dated 11/23/21, indicated R4 had a pressure injury stage 4 to coccyx, and that R4's pressure injuries would show signs of healing and remain free from infection by/through review date of 6/17/26. R4 requested his bed as flat as possible to reduce shear and preferred to be repositioned independently. Care plan with revised date of 4/21/23, indicated staff to administer treatments as ordered and monitor for effectiveness. Provide treatment at times requested by resident. R4 preferred to sleep in every day. R4 was seen by wound care provider on 4/21/26, with subsequent note documented at 3:38 p.m.: Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 4, full thickness skin and tissue loss. Wound was present on admission. No signs and symptoms of infection. Measurements: Length 10.18 cm (centimeters). Width 9.6 cm. Depth 0 cm. Area (cm2): 72.33 cm. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous. Nursing progress note dated 4/22/26 at 12:52 p.m., indicated new wound care orders received on 4/21/26: Discontinue previous wound care orders, cleanse coccyx wound BID (twice a day) with wound cleanser, place calcium alginate (absorbent dressing used primarily for managing exudate in wounds) in wound bed, place barrier cream around peri wound, cover with ABD and tape down. During an interview on 4/23/26 at 9:10 a.m., LPN-C was shown R4's treatment administration record (TAR) for the day prior, 4/22/26, which indicated R4's dressing which had been ordered to be changed twice a day had not been changed at all. One space on the TAR was blank and the other indicated the number seven, which LPN-C stated meant R4 had been sleeping. In addition, the TAR indicated a daily dressing change to the coccyx had not been done on 4/15/26. LPN-C verified the dates where a dressing change had not been documented as being done and could not speculate as to why they had not been done.			F0686	Continued from page 27 Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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F0686 SS = D	Continued from page 28 During an interview and observation on 4/23/26 at 9:44 a.m., in R4’s room, LPN-C stated generally R4 prioritized his wound care and she was not aware of him refusing dressing changes. LPN-C stated she generally talked to R4 at the start of her shift and the two agreed upon a time to do the dressing change. While LPN-C was preparing supplies for the dressing change, R4 stated his dressing had not been changed since the provider changed it on 4/21/26. R4 stated he didn’t know why the nurse on duty had not changed it the evening prior. R4 stated he rarely refused care and did not mind if staff woke him to change his dressing. R4’s sacral wound was significant and covered nearly the entirety of both buttocks and was approximately the size of a woman’s hand. Minimal exudate observed, flesh and pink in color. No odor. LPN-C changed the dressing according to the orders. During an interview on 4/23/26 at 1:02 p.m., regional clinical consultant (RCC)-D was informed a twice a day dressing changes had not been done at all on 4/22/26. RCC-D stated she would have expected staff to have completed dressing changes on 4/22/26, as ordered by the provider, and especially since the provider changed the wound care orders on 4/21/26, potentially indicating previous orders were not effective. During a telephone interview on 4/23/26 at 3:48 p.m., advanced practice registered nurse (APRN)-F was informed after his visit to R4 on 4/21/26, and changing the R4’s dressing change orders, R4’s dressing had not been changed until today, 4/23/26. APRN-F stated he expected staff to perform R4’s dressing changes as ordered. APRN-F stated he changed the order because R4 had been having problems with his skin from the Mepilex (a dressing with absorbent foam and an adhesive border) so he changed the order to cloth tape. In addition, APRN-F stated he added calcium alginate to the dressing change orders to absorb more of the drainage, adding R4’s wound had seemed to plateau in healing, and therefore, “Important to stay on top of it.” Facility Wound Treatment Management policy dated 2023, indicated to promote wound healing of various types of wounds, it was the policy of the facility to provide evidence -based treatments in accordance with current standards of practice and physician orders. Wound treatments would be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Treatments would be			F0686			06/12/2026

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F0686 SS = D	Continued from page 29 documented on the treatment administration record.			F0686			06/12/2026
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, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were addressed or acted upon for			F0756	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Pharmacy Recommendation Process management was assumed by the Director of Clinical Services on 4/22/2026 Interim DON was replaced on 5/18/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected Pharmacy recommendations noted to be outstanding on in-house residents for past 90 days were completed by 6/2/2026 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Education was provided to DON on management of pharmacy recommendation system by Director of Clinical Services on 6/11/2026 Compliance with pharmacy recommendation follow up will be reviewed monthly by the registered pharmacist monthly and reported to QAPI Pharmacy Recommendations will be audited monthly x 3 months or until substantial compliance is obtained by the Director of Clinical Services to ensure recommendations are addressed appropriately Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results		06/12/2026

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F0756 SS = D	Continued from page 30 2 of 5 residents (R8, R28) reviewed for unnecessary medications. Findings include: R28's face sheet received on 4/23/26, included diagnoses of wedge compression fracture of lumbar vertebrae, hypertension, dependence on renal dialysis, hyperlipidemia (high levels of fat in the blood), depression, diabetes, congestive heart failure (heart not able to pump enough blood) and anemia. R28's quarterly Minimum Data Set (MDS) assessment dated 11/24/25, indicated her brief interview for mental status (BIMS) was 99, indicating the cognitive interview was not able to be completed. R28 had clear speech, could understand and be understood. Behaviors included rejection of care and verbal behaviors directed towards others. R28 was dependent upon staff for activities of daily living (ADLs) and didn't walk. R28's orders included 28 medications. R28's care plan identified diagnoses and problem areas with goals and interventions. Record review indicated monthly pharmacy reviews had been conducted from 6/13/25 through 4/21/26. Pharmacist recommendations were indicated for the following nine months: 6/13/25, 8/11/25, 10/13/25, 11/10/25, 12/5/25, plus waiting for response to previous recommendation, 1/10/26, 2/6/26, 3/9/26, plus waiting for response to previous recommendation, and 4/21/26. Requested copies of pharmacy recommendation with provider responses for each of the months. Of the nine months, only one recommendation with a provider response was provided for 10/13/25. R8's face sheet provided on 4/23/26, included diagnoses of Alzheimer's disease and dementia. R8's annual MDS assessment dated 2/25/26, indicated serve cognitive impairment, unclear speech, rarely/never understood and rarely/never understands. R8 was dependent upon staff for ADLs and did not walk. R8 was receiving hospice care. R8's orders included eight medications. R8's care plan identified diagnoses and problem areas with goals and interventions. Record review indicated monthly pharmacy reviews			F0756	Continued from page 30 of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026

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F0756 SS = D	Continued from page 31 had been conducted from 6/13/25 through 4/21/26. Pharmacist recommendations were indicated for the following four months: 6/13/25, 9/11/25, 12/5/25, and 3/9/26. Requested copies of pharmacy recommendation with provider responses for each of the months and none were received. During an interview on 4/22/26 at 12:20 p.m., the regional clinical consultant (RCC)-D stated she did not believe they would find any more recommendations with provider responses than what had already been provided. The process was the responsibility of the interim director of nursing (DON). During a telephone interview on 4/22/26 at 12:30 p.m., the consultant pharmacist (CP)-E stated getting pharmacy recommendations with a provider response back from the facility was an ongoing issue. CP-E stated she had brought it up at QAPI (quality assurance and performance improvement) meetings and the medical director was aware. CP-E stated there had been a significant number of staff changes which likely contributed to the lack of sustained improvement. CP-E stated the interim DON informed her he would develop a process and create a binder, but CP-E had not seen that happen. During an interview on 4/23/26 at 11:36 p.m., the interim DON stated pharmacy sent the recommendations to him and he put them in the provider folder at the desk for providers to review and sign. He believed the providers gave the recommendations to the nurses when complete and, "The nurses took care of them." After that, the interim DON stated the forms were scanned into the electronic medical record (EMR). The interim DON admitted he did not follow through to ensure the recommendations were address by providers, implemented, and the completed forms scanned into the EMR. Regarding R28's recommendations with provider responses, the interim DON stated he had looked for those and couldn't find them. During a telephone interview on 4/23/26 at 11:38 a.m., the medical director (MD)-C stated pharmacy recommendation reports had been talked about at QAPI and in May 2025, the facility had created a new process to ensure compliance but it had not been sustained as a result of transitions in nursing leadership. Facility Medication Regime Policy dated 2024, indicated the drug regimen of each resident was			F0756			06/12/2026

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F0756 SS = D	Continued from page 32 reviewed at least once a month by a licensed pharmacist and included a review of the resident's medical chart. The pharmacist communicated any irregularities to the facility in the following ways: 1) Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. 2) Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.			F0756			06/12/2026
F0727 SS = C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3) §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day for 5 of 7 days reviewed. This had the potential to affect all 34 residents living in the facility. Findings include: Review of nursing schedule in the last 30 days identified no registered nurse (RN) had been scheduled on 3/15/26, 3/16/26, and 4/5/26. On 4/22/26 at 11:54 a.m., the administrator stated the facility had obtained a waiver for RN coverage and the facility was currently working on filling the RN positions and actively recruiting RN staff and offering incentives. During the interview the administrator stated the facility was using agency nursing staff to fill the RN coverage, was actively			F0727	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Education was provided on 6/11/2026 by Regional Clinical Consultant on Nursing Services and Sufficient staff Policy and Nursing Services – Registered Nurse Policy to the DON, NHA, and staffing coordinator. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. An audit was conducted on staffing for the past 30 days by the Regional Clinical Consultant on 6/11/2026 to ensure there was 8 consecutive hours of RN coverage with no deficiencies identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and: Staffing will be reviewed daily Monday – Friday with weekend staffing reviewed the Friday preceding the weekend by the IDT as part of the daily stand up to ensure there are 8 consecutive RN hours scheduled On Call schedule implemented with Clinical Management staff to provide staffing assistance for call offs to ensure there is 8 consecutive hours of RN coverage with managers providing coverage if no other coverage is found.		06/12/2026

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F0727 SS = C	Continued from page 33 hiring RN's, was aware not all days had a scheduled RN, and confirmed the facility had a waiver. The administrator stated finding RN's in a rural area was difficult and the facility was competing with other facilities such as homecare, hospice, and hospitals.			F0727	Continued from page 33 Facility has contract with agency to assist in providing coverage. Facility continues ongoing efforts to recruit RN's Facility collaborates with other local facilities in the company for coverage. Facility employs a full time DON who can provide RN coverage. Describe the Quality Assurance and Process Improvement Program that will be put into place. QAPI was held on 5/19/2026 to review results of survey and approve the plan of correction. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 6/12/2026		06/12/2026