Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 6, 2026

Administrator
OAK HILLS LIVING CENTER
1314 EIGHTH STREET NORTH
NEW ULM, MN 56073

RE: CCN:245490
Cycle Start Date: April 8, 2026

Dear Administrator:

On April 8, 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 8, 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 8, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

Saint Paul, MN 55164-0900

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Administrator
OAK HILLS LIVING CENTER
1314 EIGHTH STREET NORTH
NEW ULM, MN 56073

Re: State Nursing Home Licensing Orders
Event ID: 1F35CB-H1

Dear Administrator:

The above facility survey was completed on April 8, 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

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING **01 - MAIN BUILD...** B. WING	**04/08/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH , NEW ULM, Minnesota, 56073**

(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 04/08/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Oak Hills Living 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		05/14/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245490	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/08/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. OAK HILLS LIVING CENTER is a 2 story building with no basement. The original building was constructed in 1995, two-story with no basement, and was determined to be of Type II (111) construction. In 2009 an addition was constructed, two-story with no basement, and was determined to be of Type II(111) construction. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 94 beds and had a census of 78 at the time of the survey.	K0000		05/14/2026

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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		05/14/2026
K0346 SS = F Bldg. 01	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/08/2026 at 9:10 AM, it was revealed by review of available documentation that the fire alarm system out-of-service policy was incomplete and did not list the appropriate contact information to follow. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K0346	K0346 Fire Alarm System - Out of Service Corrective Action: The Maintenance Director updated the manual and policy with the correct current Fire Marshall contact information. Actual/Proposed Completion Date: 4/9/2026 Person Responsible for Corrective Action and Monitoring: Maintenance Director and Administrator	04/09/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K0353	Corrective Action: Olympic Fire Protection Corp. completed the annual inspection on the Sprinkler System 9/16/2025. The missing calculation nameplates have been corrected and installed on the fire sprinkler riser. Olympic Fire Protection Corp. replaced the sprinkler head in the second-floor mechanical room. Actual/Proposed Completion Date:	05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245490	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/08/2026**

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K0353 SS = F Bldg. 01	Continued from page 3 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(2), and 5.2.6. These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 04/08/2026 at 9:23 AM, it was revealed by a review of available documentation that the deficiency related to the missing calculation nameplates, as noted in the annual sprinkler report, had not been corrected. 2. On 04/08/2026 at 10:31 AM, it was revealed by observation that the calculation nameplates were not installed on the fire sprinkler riser. 3. On 04/08/2026 at 11:21 AM, it was revealed by observation that there was a sprinkler showing signs of corrosion in the second floor mechanical room. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0353	Continued from page 3 5/19/2026 Person Responsible for corrective action & Monitoring: Maintenance Director and Administrator	05/19/2026
K0354 SS = F Bldg. 01	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks	K0354	K0354 Sprinkler System - Out of Service Corrective Action: The Maintenance Director has updated the policy and manual with the most current contact information for the Fire Marshall.	04/09/2026

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K0354 SS = F Bldg. 01	Continued from page 4 are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.5, and NFPA 25 (2010 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/08/2026 at 9:10 AM, it was revealed by review of available documentation that the sprinkler system out-of-service policy was incomplete and did not list the appropriate contact information to follow. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K0354	Continued from page 4 Actual/Proposed Completion Date: 4/9/2026 Person Responsible for corrective action & Monitoring: Maintenance Director and Administrator	04/09/2026
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	K0921	K0921 Electrical Equipment - Testing and Maintenance Corrective Action: The maintenance director has created a manual with a list of all the Patient-Care Related Electrical Equipment documenting the date and time the equipment was inspected. The maintenance director is installing a tag on each piece of PCREE that is needed to be tested showing the date it was inspected. The Health Unit Coordinator will inform the maintenance department of any new PCREE that needs to be inspected. The Health Unit Coordinator will also inform the maintenance department of any	06/12/2026

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K0921 SS = F Bldg. 01	Continued from page 5 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 04/08/2026 at 10:20 AM, it was revealed by a 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 Director of Maintenance verified this deficient finding at the time of discovery.	K0921	Continued from page 5 PCREE that has been taken out of use to ensure our records are current and accurate. Actual/Proposed Completion Date: 6/12/2026 Person Responsible for Correction and Monitoring: Maintenance Director, Administrator and Health Unit Coordinator.	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	K0324 Cooking Facilities Corrective Action: Full-Service Electric installed a switch in the therapy room and in the activity room that has a timer that automatically deactivates the cook top and range not exceeding a 120-minute capacity. Actual/Proposed Completion Date: 4/30/2026 Person Responsible for Corrective Action and	04/30/2026

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K0324 SS = E Bldg. 01	Continued from page 6 * 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. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 04/08/2026 at 10:41 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. 2. On 04/08/2026 at 10:53 AM, it was revealed by observation that the residential stove located in the Activity 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 Director of Maintenance verified these deficient findings at the time of discovery.	K0324	Continued from page 6 Monitoring: Maintenance Director and Administrator	04/30/2026
K0355 SS = E Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10	K0355	K0355 Portable Fire Extinguisher Corrective Action: The dietician has removed the shelving that was in this location and replaced it with a narrow shelf so that it does not block the fire extinguisher. Actual/Proposed Completion Date:	05/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245490	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/08/2026**

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K0355 SS = E Bldg. 01	Continued from page 7 This STANDARD is NOT MET as evidenced by: Based on observation, and staff interview, the facility failed to install fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12, 9.7.4.1. and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.1, and 6.1.3.3.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/08/2026 at 11:06 AM, it was revealed by observation that the fire extinguisher in the catering loading dock was obstructed with a shelving, broom, and shovel. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K0355	Continued from page 7 5/14/2026 Person Responsible for corrective action and monitoring: Dietician, Maintenance Director and Administrator	05/14/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101	K0920	K0920 Electrical Equipment - Power Cords and Extens Corrective Action: The maintenance director and the maintenance assistant removed the extension cord and purchased a longer cord in the maintenance area. The maintenance director and the maintenance assistant rearranged the appliances in the Woodland Park laundry room so that they could eliminate the extension cord and eliminating power strips from being daisy chained. Person responsible for corrective action and monitoring: Maintenance Director and Administrator	04/09/2026

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K0920 SS = E Bldg. 01	Continued from page 8 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 04/08/2026 at 10:27 AM, it was revealed by observation that there were power strips daisy chained in the maintenance office. On 04/08/2026 at 11:28 AM, it was revealed by observation that there were multiple electrical concerns in the Woodland Park Laundry room, including a refrigerator and toaster plugged into a power strips, a orange extension cord plugged into two power strips, and power strips that were daisy chained. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K0920		04/09/2026

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	245490	A. BUILDING B. WING	04/08/2026

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E0000	Initial Comments On 4/6/26-4/8/26, 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		05/18/2026
F0000	INITIAL COMMENTS On 4/6/26-4/8/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/18/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F0677	Corrective Action was completed for the resident identified during survey. On 4/8/26, the facility implemented additional task charting for R65 to ensure shaving was completed daily and as needed. This process was monitored by the RN Case Manager. The resident has since discharged from the facility.	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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F0677 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., nail care and shaving) was completed and provided for 1 of 1 resident (R65) reviewed for activities of daily living (ADLs) and who was dependent on staff for their care. Findings Include: R65's admission Minimum Data Set (MDS) assessment dated 1/23/26, identified moderate cognitive impairment, needed substantial/maximal assistance for personal hygiene including shaving and nails care; diagnoses included wedge compression fracture (spinal injury where the front (anterior) part of a vertebra collapses, forming a wedge shape while the back remains intact) of T11 -T12, hemiplegia (paralysis on one side of the body), following cerebral infarction (stroke) affecting right dominant side. R65's care plan dated 1/9/26, indicated charge nurse will provide nail care due to medical condition and hygiene interventions/ tasks indicated: wash, hands and face, shave, brush teeth, rinse mouth with mouthwash, apply deodorant, lotion, comb hair, apply makeup if applicable, wash and place glasses, insert hearing aids, peri care. R65's Task List Report dated 1/8/26, indicated: Hygiene: provide resident assistance with shaving every day and as needed. R65's treatment administration record (TAR) dated April 2026, had no scheduled documentation for nails care. R65's Resident Task Look Back 14 days for bathing answers to the question; did you provide nail care? The responses were check marks under the no column for 3/25/26 and 4/1/26, indicating the task was not completed. R65's Resident Task Hygiene Look Back 14 days (3/26/26 to 4/8/26) for shaving answers to the question; did you shave resident? The responses were check marks under the no column for 3/26/26, 3/28/26, and 3/29/26, indicating the task was not	F0677	Continued from page 1 The facility also clarified that residents identified as diabetic requiring nurse nail care must have nail care entered into the Treatment Administration Record (TAR). The confusion regarding nail care documentation resulted in nursing assistants charting "no" for completion because nail care was not placed on the TAR for nursing completion. This clarification and correction were completed on 5/15/26. A desk-side in-service will be completed by 5/22/26 with nursing assistants and licensed nurses regarding the proper procedure for notifying the nurse when a CNA charts "no" for completion of a personal hygiene task, including shaving and nail care. The facility is implementing a system change within the electronic medical record that will prompt CNA's to "notify the nurse" whenever "no" is selected for completion of a personal hygiene task. Residents requiring assistance with personal hygiene tasks, including shaving and nurse-completed nail care, had the potential to be affected. An audit of applicable residents was completed to ensure appropriate tasks and documentation are present in the TAR and task lists. The facility will monitor compliance through audits to ensure staff who chart "no" for completion of care task are appropriately notifying the nurse. Audits will be completed weekly for four weeks, then monthly for three months. Audit results will be reviewed through the QAPI process for ongoing monitoring and compliance. The audit will be overseen by the Director of Nursing.	05/22/2026

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F0677 SS = D	Continued from page 2 completed. During an observation on 4/6/26 at 11:03 a.m., R65 had facial hair along her jaw line, lower cheeks and a thin fine layer of mustache. R65's facial hair was blonde in color, had varying length (½ to ¾ inch) and coarse in texture. R65 stated “I will not have this, if I was home” referring to the facial hair. During an observation on 4/7/26 at 10:43 a.m., R65 was in recliner resting after breakfast and morning cares were completed, no noted changes in facial hair from the previous day. During an interview on 4/7/26 at 12:30 p.m., R65 stated facial hair was rough to touch, was bothered when others can see it, and wanted the facial hair shaved. R65 showed her fingernails and stated, “I would like my nails trimmed”. R65 fingernails had grown over the finger’s tips, and some were curving downward. R65 stated “one thing I noticed around here, these nurse, and aids all have beautiful nails with nice colors, and look at mine.” During an interview on 4/7/26 at 12:38 p.m., nursing assistant (NA)-A and NA-B entered R65’s room. NA-A stated was training NA-B. NA-A and NA-B acknowledged R65’s facial hair, and stated would shave after R65 was done with lunch. NA-B stated had completed R65’s cares that morning and should have shaved R65’s facial hair that morning, when it was communicated, R65 wanted facial hair shaved and nails trimmed. NA-A stated R65's “nails will be done tomorrow, she has a shower, and nails are done weekly with showers”. During an interview on 4/8/26 at 9:04 a.m., registered nurse, (RN)-A stated care on task list should be completed as assigned and the charge nurse notified of any issues with timely completion. During an interview on 4/8/26 at 10:08 a.m., RN-B known as case manager stated she expected tasks assigned to be completed and any issues reported as appropriate. Facility Care Plans, Comprehensive Person-Centered policy reviewed on 10/30/25, indicated the care plan interventions are derived from a thorough analysis	F0677		05/22/2026

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F0677 SS = D	Continued from page 3 of the information gathered as part of the comprehensive assessment.	F0677		05/22/2026
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 follow provider orders for leg compression for 1 of 1 resident (R38) reviewed for edema (swelling in the legs caused by fluid). Findings include: R38's face sheet dated 4/8/26, indicated diagnoses of chronic congestive heart failure, chronic respiratory failure, hypertension (high blood pressure), and obesity. R38's quarterly Minimum Data Set (MDS) assessment dated 2/20/26, indicated moderate cognitive impairment, no behaviors or rejection of care, use of oxygen, use of wheelchair, supervision for hygiene, partial assistance for bathing, substantial assistance for upper and lower body dressing. R38's physician's order dated 6/25/25, indicated TG shapes (seamless tubular bandage designed to provide light, graduated compression and support) to bilateral lower extremities: on in AM and off at HS (bedtime). During interview on observation on 4/6/26 at 4:18 p.m., R38 was seated in her recliner with her legs exposed. R38 had indentations in her legs from her socks and no TG shapes on her lower legs. R38 stated she did not recall ever wearing leg compression and did not know her doctor had ordered those for her. During interview and observation on 4/7/26 at 10:57 a.m., R38 was seated in her wheelchair. R38 had no	F0684	Corrective action was completed for the resident identified during survey. The facility reviewed R38's care plan and physician orders related to compression devices. On 4/13/26, the RN Case Manager implemented a task to ensure physician orders were being followed and that nursing assistants are applying the resident's compression devices as ordered. The consultant involved in the documentation error was made aware of the issue. On 4/14/26, the facility implemented a system change regarding compression device application and monitoring. Nursing assistants remain responsible for applying compression devices; however, licensed nurses are now responsible for signing off daily in the Treatment Administration Record (TAR) to verify proper application and compliance with physician orders. To address the documentation and consultant-related error identified during survey, a house-wide audit was completed on 4/24/26 to ensure all compression orders were appropriately entered into tasks and treatment documentation and that no additional orders were missed. Residents with compression orders had the potential to be affected. The audit verified all applicable orders were correctly entered and assigned for completion. On 5/19/26, the Director of Nursing educated Case Managers to ensure all physician orders have the appropriate tasks associated with them within the electronic medical record system. The facility will audit compliance with compression device orders weekly for four weeks, then monthly for three months. Audit findings will be reviewed through the QAPI process to ensure ongoing compliance and identify any needed corrective actions. The audit will be overseen by the Director of Nursing.	05/19/2026

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F0684 SS = D	Continued from page 4 TG shapes on her lower legs and stated she used to wrap her legs herself but could not remember having anything on her legs for compression while at the facility. During interview on 4/7/26 at 11:46 a.m., nursing assistant (NA)-C stated she was not aware R38 had an order for TG shapes and had not ever put TG shapes on for R38. NA-C verified applying TG shapes to bilateral lower legs was not on R38's task list. During interview on 4/7/26 at 12:04 p.m., licensed practical nurse (LPN)-A stated there was an order for TG shapes on R38's order, but it stated no directions indicated for order, which meant it did not forward on for anyone to complete. LPN-A stated TG shapes were not on the tasks for NA's to complete, so likely why it wasn't being done. During interview on 4/7/26 at 12:55 p.m., registered nurse (RN)-C also known as case manager, stated she had heard from LPN-A about R38's TB shapes order not being followed. RN-C further stated she looked through R38's chart and verified the order should have been on the tasks for the NA's to complete, but a consultant had accidentally taken it off the tasks on 2/10/26, and no one had caught that it was missing. RN-C stated it was important to follow provider's order for TG shapes due to R38's diagnosis of congestive heart failure. During interview on 4/7/26 at 2:41 p.m., director of nursing (DON) stated a consultant was working on cleaning up Point Click Care (PCC, an electronic health record), and had removed the order from tasks but forgot to put it back on. DON stated provider's orders should be followed for all residents. Facility Medication and Treatment Orders policy printed 4/8/26, did not include anything related to compression orders but stated: Orders for medications and treatments will be consistent with principles of safe and effective order writing.	F0684		05/19/2026