DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 17, 2026

Administrator
FIRST CARE LIVING CENTER
900 HILLIGOSS BOULEVARD SOUTHEAST
FOSSTON, MN 56542

RE: CCN: 245512
Cycle Start Date: May 28, 2026

Dear Administrator:

On July 8, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Care Living Center	900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542

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E0000	Initial Comments On 5/26/26 through 5/28/26, 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		06/11/2026
F0000	INITIAL COMMENTS On 5/26/26 through 5/28/26, 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 complaint H55122520C (2969890) was reviewed, no deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		06/11/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F0585	The following actions were taken to correct the deficiency: On 5/28/26, the SSD and DON discussed the grievance with R22. R22 was encouraged to use the call light or hand bell when unwanted residents enter his room. Staff will redirect the R8 to her room	06/24/2026

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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F0585 SS = D	Continued from page 1 that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F0585	Continued from page 1 after meals and/or when she is wandering outside her room to help prevent R8 from entering R22's room. R22 was informed that a sign or doorway item will be ordered to prompt other residents to pause before entering his room. R22 agreed with the plan. DON reviewed the last 30 days of progress notes for all residents to look for grievances/complaints and verify status of resolution. Of the current 29 residents, 9 residents had some type of concern or complaint reported. 3 of them were still in process waiting for items to be repaired or response from vendors. The only complaint/grievance that had not been addressed was the complaint documented on 5/21/26 by R22. All residents and families' complaints and grievances will be tracked of complaint/grievance spreadsheet available to all RN supervisors, SSD, and DON. The grievance form will be completed by staff receiving complaints. The form will be handed off to the Grievance officer/DON to be investigated. When resolution is obtained, the form will be signed off by the Grievance Officer and/or DON. All staff were educated to notify SSD and/or DON of any resident/family complaints or grievances. Grievance forms and Grievance Standard Work will be sent to all residents and families and discussed at July resident council meeting. The following measures were implemented to prevent the deficiency from recurring: Adopted Grievance form for all complaints/grievances Complaints/Grievances will be investigated and resolution signed off by Grievance officer and DON. Staff educated on forms/processes and location of forms	06/24/2026

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F0585 SS = D	Continued from page 2 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to investigate, document, and track resolution of a resident grievance regarding another resident (R8) entering their room and going through their belongings for 1 of 1 resident (R22) reviewed for grievances. Findings include: R22's quarterly Minimum Data Set (MDS) dated 3/11/26, identified R22 was cognitively intact and required set up and clean up assistance with eating and oral hygiene. R22 was dependent on staff in all other care areas. Diagnoses included hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness). R8's comprehensive MDS dated 4/13/26, identified	F0585	Continued from page 2 Standard Work & Forms sent out to residents/families to verify their knowledge of the process. Grievances will be reviewed by IDT at daily huddles and by QAPI team at monthly meetings. All staff were educated on grievance form, Grievance Standard Work, and reporting process in person by their direct RN supervisor and in weekly update posted and sent out to all staff on 6/22/26. The facility will monitor the following to ensure solutions are sustained: Completion of Grievance Form, recording on spreadsheet, documentation of follow up/resolution All complaints/grievances will be audited weekly by IDT for status and resolution. Audit results and complaints/grievances will also be reported monthly at QAPI meetings When 100% compliance has been maintained, QAPI will determine the frequency of ongoing audits. Staff responsible for the corrective actions and monitoring of compliance: Kristi Mienert Date Corrected (all actions completed): 6/24/2026 Anticipated Date of Full Compliance: 6/24/2026	06/24/2026

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F0585 SS = D	Continued from page 3 R8 had severe cognitive impairment and had diagnoses that included dementia, depression and psychotic disorder. R22's nursing progress note dated 5/21/26 at 4:57 a.m., identified R22 wanted to talk to someone in charge in the morning about R8 digging in his drawers. R22's care plan revised 4/1/26, failed to identify R22 wishes to prevent other residents from entering his room uninvited. R22's medical record failed to identify any further documentation related to R22's concerns related to R8. A review of the facility's formal grievances and informal grievances dated 8/1/25 through 5/26/26, failed to identify R22's grievance including investigation and action taken by the facility. During an interview on 5/26/26 at 1:12 p.m., R22 stated R8 came into his room and accused him of stealing her things, especially R8's dentures. R22 stated he turned on his call light but by the time staff arrived R8 had already left. R22 stated he had told staff he didn't like R8 coming into his room and they told him to turn on his call light if R8 did. During an interview on 5/28/26 at 10:44 a.m., the social worker designee (SWD) stated when a resident filed a complaint or grievance, staff went over the grievance form with the resident if the resident wanted to make a formal grievance. If the resident just wanted to vent whatever the issue was, they would talk with the resident and make a way to fix it. The SWD kept a spreadsheet so all concerns would be tracked whatever the issue was. However, the SWD stated there was no documentation regarding R22's grievance because R22 had never wanted to file a formal grievance and R22's daughter had stated understanding with the situation. R22 did have a right to privacy in his room, and it was R22's right to file a grievance. The SWD had not documented an informal grievance for R22 and stated there should have been documentation. During an interview on 5/28/26 at 11:18 a.m., the director of nursing (DON) stated she expected staff to follow the grievance process whether it was formal or informal because staff needed to track all grievances to determine if there was a resolution or if the interventions implemented were working or not. The facility policy Resident grievances dated 4/21/26, identified a resident has the right to voice	F0585		06/24/2026

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F0585 SS = D	Continued from page 4 grievances (orally or in writing) without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff or other residents, and other concerns regarding their stay in the SNF. The resident has the right to, and the facility must make, Prompt efforts to resolve grievances the resident may have. The Resident may file grievances orally or in writing and may also file a grievance anonymously. All grievances will be responded to within seven (7) days of receipt. A grievance in which the Resident or Resident Representative requests be handled as a written formal grievance will be investigated and responded to in writing. Written responses to grievances will include a. The date the grievance was received, b. A summary statement of grievance; c. The steps taken to investigate the grievance; d. A summary of the pertinent findings or conclusions e. A statement as to whether the grievance was confirmed or not confirmed, f. Any corrective action taken or to be taken by the facility because of the grievance; and g. The date the written decision was issued, if required. Regardless of whether a written decision is required to be issued to a Resident or Resident Representative, the facility will document in writing (for its own records) all decisions.	F0585		06/24/2026
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate wandering behaviors, including entering other residents' rooms and going through personal belongings, for 1 of 3 residents (R8) reviewed for behavioral symptoms. Findings include: R8's significant change Minimum Data Set (MDS) dated 4/1/26, identified R8 had severe cognitive impairment and identified a worsening of behaviors.	F0744	Actions taken immediately to stop the deficient practice and protect residents: Reviewed care plan of R8 and all other residents identified as high risk for wandering. Care plans were updated to include interventions addressing wandering. The following measures were implemented to prevent the deficiency from recurring: Reviewed and updated observation/assessments, BIMS, and care plans of all residents with confusion, dementia, have a history of wandering, and/or have been identified as residents at risk for wandering. Retractable magnetic belt ordered to place on doorframes of rooms resident wander in to deter	06/24/2026

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F0744 SS = D	Continued from page 5 R8's diagnoses included: non-Alzheimer's dementia, depression, hallucinations and a psychotic disorder other than schizophrenia. R8's behavioral symptoms Care Area Assessment (CAA) dated 4/9/26, identified R8 had worsening behaviors along with hallucinations. R8's behaviors included: isolation, pain, anxiety, hollering out, and disruptive sounds; however, did not comprehensively assess wandering or a plan to minimize it. R8's progress note dated 5/20/26, identified R8 had been wandering into three other resident's rooms tonight and had been caught by staff digging in drawers. During observations on 5/26/26 at 12:53 p.m., R8 had wandered down the south hallway and entered another resident's room. As the surveyor walked by R8 came out of the room and asked where her room was. During an interview on 5/26/26 at 1:12 p.m., R22 stated R8 came into his room and accused him of stealing her things, especially R8's dentures. "I tell her I don't need her teeth, that I have my own." R8 would call R22 "every name in the book". R8 was rummaging in R22's closet and said all R22's things belonged to R8. R22 stated R8 just kept stating "it's mine!" R22 told R8 to get out of his room and R22 was upset by what R8 said and did. R22 stated he turned on his call light but by the time staff arrived R8 had already left. R22 stated he had told staff he didn't like R8 coming into his room and they told him to turn on his call light if R8 did. [R22's quarterly MDS dated 3/11/26 identified R22 was cognitively intact.] During an interview on 5/28/26 at 8:53 a.m., registered nurse (RN)-D stated R8 did wander into other residents' rooms "from time to time". For a long time, R8 believed R22 was the doctor and would go into R22's room to talk to him. After meals, staff tried to direct her to her room. RN-D stated she did not work in the evening or night but believed R8 wandered into other rooms more frequently during that time because R8's sundowning (a state of increased confusion, anxiety, and agitation that affects people with dementia.) RN-D did not know of any interventions to prevent R8 from entering other residents' rooms. "It's just redirection." RN-D did not identify the assessment process for wandering. During an interview on 5/28/26 at 9:08 a.m., trained	F0744	Continued from page 5 them. Estimated delivery on 6/22/26. 6/23/26 Retractable belt installed on doorframe in room R22. Daughter and resident educated on the purpose and use of the belt. Per Elopement Prevention Standard Work: All residents will be assessed and behaviors reviewed by RN on admission, quarterly, and on an as needed basis to determine if additional interventions are needed to protect themselves and others. Elopement precautions will be initiated immediately for all residents deemed at high risk for elopement per the nurse's discretion based on the resident's assessments/observation. Interventions may be discontinued by RN after the IDT reviews the RNs' recommendations. A plan of preventive elopement and wandering interventions will be incorporated into the residents' plan of care. Staff Education: All staff educated in daily team huddles and through 6/22/26 weekly updates sent to all staff: Education included items added to care plan, interventions to redirect residents, and Elopement prevention standard work. All staff complete the required EduCare Dementia education annually. Upon receipt, estimated 6/22/26, staff will be educated on retractable magnetic belts for doorway to deter R8 from wandering into rooms. Monitoring & Audit Plan to Sustained Compliance: Care plans of resident RNs staff identify as residents' high risk for wandering will be audited to verify the care plan is up to date in regard to interventions related to wandering.	06/24/2026

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F0744 SS = D	Continued from page 6 medication assistant/nursing assistant (NA)-A stated R8 wandered a lot and went in and out of other residents' rooms. R8 was always easily redirected, and she would go to her room. There was nothing care planned about wandering, but staff always kept a close eye on R8 when she was out of her room. During an interview on 5/28/26 at 9:11 a.m., NA-B stated she had never seen R8 go into R22's room but had heard about it. When R8 was wandering staff just tried to keep an eye on R8 and redirect her back to her room. "I think that's all you can do." During an interview on 5/28/26 at 10:44 a.m., the social worker designee (SWD) stated at one point, R8 had entered R22's room and accused them of taking her dentures. Staff tried a lot of redirection with R8 because she was fixated on her dentures. There was no regular documentation of R8's behavior. SWD did not identify the assessment process for wandering. During an interview on 5/8/26 at 10:54 a.m., registered nurse supervisor (RN)-A stated R8 would get mixed up on where she was and would wander down the hall and enter other residents' rooms. Most of the time she was easily redirected, but other times R8 would start going through other residents' personal belongings. R8 required a lot of redirection to find her way back to her room. RN-A stated they were currently trying to always keep an eye on R8 when she was out of her room. R8's wandering should have been assessed and identified in the care plan due to being consistent behavior for her. During an interview on 5/28/26 at 11:14 a.m., the director of nursing (DON) stated resident care plans should have identified any regular resident behaviors and any interventions implemented. R8 did wander and enter into other residents' rooms and in recent months and had an escalation in wandering. R8 usually wanders right after meals, and they try to keep an eye on her and will redirect R8 back to her room. R8's should have been assessed and the care plan should have been updated to identify the wandering behavior and interventions in place. A wandering policy was requested, but it was not received.	F0744	Continued from page 6 All care plans are reviewed by IDT on admission, quarterly during care conferences, and as needed for accuracy. 5 resident care plans and documentation will be audited weekly by IDT and at reported monthly at QAPI meetings When 100% compliance has been maintained, QAPI will determine the frequency of ongoing audits. Staff responsible for the corrective actions and monitoring of compliance: Kristi Mienert RN, DON Date Corrected (all actions completed): 6/24/26 Anticipated Date of Full Compliance: 6/24/26	06/24/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F0883	Actions taken immediately to stop the deficient practice and protect residents: Education completed with RN team on up-to-date status of pneumococcal conjugate immunizations.	06/24/2026

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F0883 SS = D	Continued from page 7 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F0883	Continued from page 7 R20 & R27 reviewed with current recommendations. PneumoRec program recommended Shared Clinical Decision Making to determine need/consent for PCV20 or PCV21. Education provided to including CDC Pneumo Vaccine Timing Job Aid, CDC Shared Clinical Decision Making for PCV and PCV VIS 5/29/2025. R20 verbalized consent for PCV20 but not for a few weeks due to currently being treated for UTI. R20 vocalized desire to return to baseline prior to receiving vaccine. R27 declined any additional vaccines. R27 stated that they would not be receiving any additional vaccines. Infection prevention nurse reviewed all resident records to see if any residents needed vaccines to bring up-to-date and/or there was documentation of education with resident/family declination of vaccinations. The following measures were implemented to prevent the deficiency from recurring: New Immunization Standard Work developed to incorporate system information with specific workflows for First Care Living Center facility. RN supervisors and IP RN educated on current pneumococcal conjugate immunization recommendations, New Standard Work, how to use PneumoRec, proper documentation in admission and immunization observation, and proper documentation of consents, declinations, and delays in administering vaccinations. Staff Education: 6/15-6/19/26 RN staff completing admissions and immunization observations on: Use of PneumoRec vaccination program.	06/24/2026

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F0883 SS = D	Continued from page 8 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess pneumococcal immunization status, provide education, and document discussion and offering of pneumococcal vaccination in accordance with current CDC recommendations for 2 of 5 residents (R20, R27) reviewed for immunizations. Findings include: R20: R20's admission Minimum Data Set (MDS) dated 5/1/26, identified R20 was admitted on 4/20/26, was cognitively intact and able to make her needs known. R20's diagnoses included diabetes and hypertension. R20's Preventive Health Care Report dated 5/25/10 through 5/28/26, identified R20 received Prevnar13 on 6/17/15. R20's electronic health record failed to include evidence R20 or R20's representative received education regarding pneumococcal vaccine booster and there was no indication R20 was offered the pneumococcal vaccine per CDC guidance in conjunction with their provider. R27: R27's annual MDS dated 3/31/26 identified R27 was admitted to the facility on 3/17/26 and was 75 years old. R27's diagnoses included coronary heart disease, heart failure, and thyroid disease. The facility immunization report dated 5/28/26, identified R27 received PCV13 on 8/30/17, and PPSV23 on 11/16/18. R27's electronic health record failed to include evidence R27or R27's representative received education regarding pneumococcal vaccine booster and there was no indication R27 was offered the pneumococcal vaccine per CDC guidance in conjunction with their provider. On 5/27/26 at 1:28 p.m., registered nurse (RN)-D stated immunizations were offered upon admission and seasonally. RN-A stated she reviewed the resident's immunization status upon admission.	F0883	Continued from page 8 Process for review vaccination records, vaccination education, obtaining consent, ordering vaccination, administration, and documentation of refusals, consents, and administrations. Updated Immunization Standard Work for FCLC. Monitoring & Audit Plan to Sustained Compliance: All residents and their vaccinations will be entered on the infection prevention nurse immunization spreadsheet. Weekly audits will be completed on all new admissions and current residents to verify if any residents are due for vaccinations. Vaccination spreadsheet will be audited weekly by IP RN. Records of 25% of residents, including all new admissions, will be audited weekly using Immunization Observation Tracer. Tracer includes reviewal of vaccination observation and documentation of education, consent, and administration. Audits will be reviewed weekly by IDT and reported monthly at QAPI meetings When 100% compliance has been maintained, QAPI will determine the frequency of ongoing audits. Staff responsible for the corrective actions and monitoring of compliance: Kristi Mienert RN, DON Date Corrected (all actions completed): 6/24/26 Anticipated Date of Full Compliance: 6/24/26	06/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Care Living Center	900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542

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F0883 SS = D	Continued from page 9 Immunizations were either administered, or a declination was signed after they were discussed with the resident and/or resident representative. On 5/28/26 at 8:53 a.m., the director of nursing (DON) stated she was uncertain what process the infection preventionist (IP) used to determine when a resident was due for the pneumococcal vaccine, although had recommended using the PnuemoRecs VaxAdvisor App or website (a standalone application that provides patient-specific guidance related to pneumococcal immunization schedule). The DON stated she was uncertain if R27 had received the most recent pneumococcal immunization. The DON stated there were no notes in the medical record identifying that the pneumococcal immunization was discussed or offered to R20 or R20's representative. Further, DON stated she expected all immunizations would be discussed with the resident and/or resident representative upon admission and per CDC guidance, as well as documenting a progress note in the resident's medical record. The Essentia Health Standard Work Process dated 3/5/26, identified staff reviewed vaccination history for all residents at the time of admission and assess if the resident needed vaccinations including pneumococcal. Staff provided and discussed the most current Vaccination Information Statement (VIS) with each resident and/or resident representative prior to administration, and document administration or declination in the resident's medical record. The CDC Pneumococcal Vaccine Recommendations dated 2/25/26 identified The United States uses 2 types of pneumococcal vaccines. Each individual vaccine helps protect against different serotypes of pneumococcal bacteria. Pneumococcal conjugate vaccines (PCVs) PCV15, PCV20 and PCV21; and Pneumococcal polysaccharide vaccine (PPSV23). Adults 50 years or older Administer PCV15, PCV20, or PCV21 for all adults 50 years or older, who have never received any pneumococcal conjugate vaccine, whose previous vaccination history is unknown. PCV15: Additional vaccination recommended If PCV15 is used, administer a dose of PPSV23A one year later. Only one dose of PPSV23 is indicated. If PPSV23 was previously administered, another dose isn't needed. The patient's pneumococcal vaccinations are complete. The minimum interval is 8 weeks and can be considered in adults with: An immunocompromising condition. A cochlear implant, A cerebrospinal fluid leak. PCV20 or PCV21: Additional vaccination not recommended If PCV20 or PCV21 is used, a dose of PPSV23 isn't indicated. Regardless of which vaccine is used (PCV20 or	F0883		06/24/2026

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F0883 SS = D	Continued from page 10 PCV21), the patient's pneumococcal vaccinations are complete. Recommendation for shared clinical decision-making: Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of 65 years old.	F0883		06/24/2026
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine;	F0887	Actions taken immediately to stop the deficient practice and protect residents: Education completed with RN team on up-to-date status of immunizations. R20 & R27 reviewed with current recommendations. Review determined R20 & R27 are due for COVID-19 vaccine. Education provided to include CDC COVID-19 VIS 01.31.2025. R20 verbalized consent for vaccines but not for a few weeks due to currently being treated for UTI. R20 vocalized desire to return to baseline prior to receiving vaccine. R27 declined any additional vaccines. R27 stated that they would not be receiving any additional vaccines. Infection prevention nurse reviewed all resident records to see if any residents needed vaccines to bring up-to-date and/or there was documentation of education with resident/family declination of vaccinations. Contacted Nords LTC pharmacy and Essentia Health pharmacy team to determine the availability of vaccines if Nords LTC pharmacy does not have supply. Verification received from Essentia Health Fosston CAH pharmacy that they have ability to order COVID-19 vaccine at any time if they do not have a supply onsite. Staff Education:	06/24/2026

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F0887 SS = D	Continued from page 11 and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess COVID-19 vaccination status and ensure current CDC-recommended COVID-19 vaccination was offered and documented for 2 of 5 residents (R20, R27) reviewed for immunizations. Findings include: R20: R20’s admission Minimum Data Set (MDS) dated 5/1/26, identified R20 was admitted on 4/20/26, was cognitively intact and able to make her needs known. R20’s diagnoses included diabetes and hypertension. R20's Preventative Health Care Report identified the last documented COVID-19 vaccination was administered on 11/23/21. The medical record lacked evidence the resident's COVID-19 vaccination status was assessed upon admission, that current CDC recommendations were discussed, or that the resident was offered recommended COVID-19 vaccination since admission on 4/20/26. R27: R27’s annual MDS dated 3/31/26 identified R27 was admitted to the facility on 3/17/26 and was 75 years old. R27’s diagnoses included coronary heart	F0887	Continued from page 11 6/15-6/19/26 RN staff completing admissions and immunization observations on: Process for review vaccination records, vaccination education, obtaining consent, ordering vaccination, administration, and documentation of refusals, consents, and administrations. Updated Immunization Standard Work for FCLC. Systemic Corrective Actions to prevent recurrence: On admission, quarterly, and with season changes, residents’ vaccination status will be reviewed to see if vaccinations are up to date. If COVID-19 vaccination is needed and resident/family give consent for vaccination, the vaccine will be ordered from Nords LTC pharmacy. If Nords LTC pharmacy is unable to obtain COVID-19 vaccine, Essentia Health Fosston hospital pharmacy will be contacted to obtain vaccine. Resident/family will be notified if vaccine needs to be ordered with estimated timeline for administration. Immunization Standard Work developed to integrate process for ordering vaccination and alternative sources if vaccine is unavailable from primary ordering source. Standard work includes notification of resident/family if vaccination is delayed for any reason. Monitoring & Audit Plan to Sustained Compliance: All residents and their vaccinations will be entered on the infection prevention nurse immunization spreadsheet.	06/24/2026

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F0887 SS = D	Continued from page 12 disease, heart failure, and thyroid disease. R27's medical record lacked evidence staff assessed the resident's COVID-19 vaccination status upon admission, provided education regarding current CDC recommendations, offered vaccination, or obtained a documented declination. On 5/27/26 at 1:28 p.m., registered nurse (RN)-D, who is also the infection preventionist, stated immunizations were offered upon admission and seasonally. RN-A stated she reviewed the resident's immunization status upon admission. Immunizations were either administered, or a declination was signed after they were discussed with the resident and/or resident representative. On 5/28/26 at 8:53 a.m., the director of nursing (DON) stated she expected all immunizations would be discussed with the resident and/or resident representative upon admission and per CDC guidance, as well as documenting a progress note in the resident's medical record. The Essentia Health Standard Work Process dated 3/5/26, identified staff reviewed vaccination history for all residents at the time of admission and assess if the resident needed vaccinations including COVIS-19. Staff provided and discussed the most current Vaccination Information Statement (VIS) with each resident and/or resident representative prior to administration, and document administration or declination in the resident's medical record. The Centers for Disease Control 2025–2026 COVID-19 Vaccination Guidance dated 11/4/25, identified COVID-19 vaccination is recommended for all adults ages 65 years and older based on individual-based decision-making (also known as shared clinical decision-making). For people ages 6 months–64 years, vaccination is recommended based on individual-based decision-making (also known as shared clinical decision-making)—with an emphasis that the risk-benefit of vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk, according to the CDC list of COVID-19 risk factors. In addition to the CDC list, the Moderna (Spikevax) package insert states that prematurity (birth at <37 weeks gestational age) has been associated with COVID-19-related hospitalizations in children ages 6–23 months. Ages 65 years and older Unvaccinated: Administer 2 doses of 2025–2026 vaccine; Unvaccinated 2025–2026 Dose 1 (Moderna, Novavax, or Pfizer-BioNTech): Day 0 2025–2026	F0887	Continued from page 12 Weekly audits will be completed on all new admissions and current residents to verify if any residents are due for vaccinations. Vaccination spreadsheet will be audited weekly by IP RN. Records of 25% of residents, including all new admissions, will be audited weekly using Immunization Observation Tracer. Tracer includes reviewal of vaccination observation and documentation of education, consent, and administration. Audits will be reviewed weekly by IDT and reported monthly at QAPI meetings When 100% compliance has been maintained, QAPI will determine the frequency of ongoing audits. Staff responsible for the corrective actions and monitoring of compliance: Kristi Mienert RN, DON Date Corrected (all actions completed): 6/24/26 Anticipated Date of Full Compliance: 6/24/26	06/24/2026

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F0887 SS = D	Continued from page 13 Dose 2 (Moderna [Spikevax], Novavax, or Pfizer-BioNTech): 6 months (minimum interval 2 months) after 2025–2026 Dose 1; (Moderna [mNexspike]): 6 months (minimum interval 3 months)‡ after 2025–2026 Dose 1. Previously vaccinated before 2025–2026 vaccine: Administer 2 doses of 2025–2026 vaccine 1 or more doses any COVID-19 vaccine (Moderna, Novavax, or Pfizer-BioNTech) 2025–2026 Dose 1 (Moderna [Spikevax], Novavax, or Pfizer-BioNTech): At least 8 weeks after last dose; (Moderna [mNexspike]): At least 3 months after last dose‡2025–2026 Dose 2 (Moderna [Spikevax], Novavax, or Pfizer-BioNTech): 6 months (minimum interval 2 months) after 2025–2026 Dose 1; (Moderna [mNexspike]): 6 months (minimum interval 3 months)‡ after 2025–2026 Dose 1.	F0887		06/24/2026

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E0000	Initial Comments On 5/26/26 through 5/28/26, 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		06/11/2026
F0000	INITIAL COMMENTS On 5/26/26 through 5/28/26, 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 complaint H55122520C (2969890) was reviewed, no deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		06/11/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F0585	The following actions were taken to correct the deficiency: On 5/28/26, the SSD and DON discussed the grievance with R22. R22 was encouraged to use the call light or hand bell when unwanted residents enter his room. Staff will redirect the R8 to her room	06/24/2026

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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F0585 SS = D	Continued from page 1 that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F0585	Continued from page 1 after meals and/or when she is wandering outside her room to help prevent R8 from entering R22's room. R22 was informed that a sign or doorway item will be ordered to prompt other residents to pause before entering his room. R22 agreed with the plan. DON reviewed the last 30 days of progress notes for all residents to look for grievances/complaints and verify status of resolution. Of the current 29 residents, 9 residents had some type of concern or complaint reported. 3 of them were still in process waiting for items to be repaired or response from vendors. The only complaint/grievance that had not been addressed was the complaint documented on 5/21/26 by R22. All residents and families' complaints and grievances will be tracked of complaint/grievance spreadsheet available to all RN supervisors, SSD, and DON. The grievance form will be completed by staff receiving complaints. The form will be handed off to the Grievance officer/DON to be investigated. When resolution is obtained, the form will be signed off by the Grievance Officer and/or DON. All staff were educated to notify SSD and/or DON of any resident/family complaints or grievances. Grievance forms and Grievance Standard Work will be sent to all residents and families and discussed at July resident council meeting. The following measures were implemented to prevent the deficiency from recurring: Adopted Grievance form for all complaints/grievances Complaints/Grievances will be investigated and resolution signed off by Grievance officer and DON. Staff educated on forms/processes and location of forms	06/24/2026

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F0585 SS = D	Continued from page 2 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to investigate, document, and track resolution of a resident grievance regarding another resident (R8) entering their room and going through their belongings for 1 of 1 resident (R22) reviewed for grievances. Findings include: R22's quarterly Minimum Data Set (MDS) dated 3/11/26, identified R22 was cognitively intact and required set up and clean up assistance with eating and oral hygiene. R22 was dependent on staff in all other care areas. Diagnoses included hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness). R8's comprehensive MDS dated 4/13/26, identified	F0585	Continued from page 2 Standard Work & Forms sent out to residents/families to verify their knowledge of the process. Grievances will be reviewed by IDT at daily huddles and by QAPI team at monthly meetings. All staff were educated on grievance form, Grievance Standard Work, and reporting process in person by their direct RN supervisor and in weekly update posted and sent out to all staff on 6/22/26. The facility will monitor the following to ensure solutions are sustained: Completion of Grievance Form, recording on spreadsheet, documentation of follow up/resolution All complaints/grievances will be audited weekly by IDT for status and resolution. Audit results and complaints/grievances will also be reported monthly at QAPI meetings When 100% compliance has been maintained, QAPI will determine the frequency of ongoing audits. Staff responsible for the corrective actions and monitoring of compliance: Kristi Mienert Date Corrected (all actions completed): 6/24/2026 Anticipated Date of Full Compliance: 6/24/2026	06/24/2026

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F0585 SS = D	Continued from page 3 R8 had severe cognitive impairment and had diagnoses that included dementia, depression and psychotic disorder. R22's nursing progress note dated 5/21/26 at 4:57 a.m., identified R22 wanted to talk to someone in charge in the morning about R8 digging in his drawers. R22's care plan revised 4/1/26, failed to identify R22 wishes to prevent other residents from entering his room uninvited. R22's medical record failed to identify any further documentation related to R22's concerns related to R8. A review of the facility's formal grievances and informal grievances dated 8/1/25 through 5/26/26, failed to identify R22's grievance including investigation and action taken by the facility. During an interview on 5/26/26 at 1:12 p.m., R22 stated R8 came into his room and accused him of stealing her things, especially R8's dentures. R22 stated he turned on his call light but by the time staff arrived R8 had already left. R22 stated he had told staff he didn't like R8 coming into his room and they told him to turn on his call light if R8 did. During an interview on 5/28/26 at 10:44 a.m., the social worker designee (SWD) stated when a resident filed a complaint or grievance, staff went over the grievance form with the resident if the resident wanted to make a formal grievance. If the resident just wanted to vent whatever the issue was, they would talk with the resident and make a way to fix it. The SWD kept a spreadsheet so all concerns would be tracked whatever the issue was. However, the SWD stated there was no documentation regarding R22's grievance because R22 had never wanted to file a formal grievance and R22's daughter had stated understanding with the situation. R22 did have a right to privacy in his room, and it was R22's right to file a grievance. The SWD had not documented an informal grievance for R22 and stated there should have been documentation. During an interview on 5/28/26 at 11:18 a.m., the director of nursing (DON) stated she expected staff to follow the grievance process whether it was formal or informal because staff needed to track all grievances to determine if there was a resolution or if the interventions implemented were working or not. The facility policy Resident grievances dated 4/21/26, identified a resident has the right to voice	F0585		06/24/2026

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F0585 SS = D	Continued from page 4 grievances (orally or in writing) without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff or other residents, and other concerns regarding their stay in the SNF. The resident has the right to, and the facility must make, Prompt efforts to resolve grievances the resident may have. The Resident may file grievances orally or in writing and may also file a grievance anonymously. All grievances will be responded to within seven (7) days of receipt. A grievance in which the Resident or Resident Representative requests be handled as a written formal grievance will be investigated and responded to in writing. Written responses to grievances will include a. The date the grievance was received, b. A summary statement of grievance; c. The steps taken to investigate the grievance; d. A summary of the pertinent findings or conclusions e. A statement as to whether the grievance was confirmed or not confirmed, f. Any corrective action taken or to be taken by the facility because of the grievance; and g. The date the written decision was issued, if required. Regardless of whether a written decision is required to be issued to a Resident or Resident Representative, the facility will document in writing (for its own records) all decisions.	F0585		06/24/2026
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate wandering behaviors, including entering other residents' rooms and going through personal belongings, for 1 of 3 residents (R8) reviewed for behavioral symptoms. Findings include: R8's significant change Minimum Data Set (MDS) dated 4/1/26, identified R8 had severe cognitive impairment and identified a worsening of behaviors.	F0744	Actions taken immediately to stop the deficient practice and protect residents: Reviewed care plan of R8 and all other residents identified as high risk for wandering. Care plans were updated to include interventions addressing wandering. The following measures were implemented to prevent the deficiency from recurring: Reviewed and updated observation/assessments, BIMS, and care plans of all residents with confusion, dementia, have a history of wandering, and/or have been identified as residents at risk for wandering. Retractable magnetic belt ordered to place on doorframes of rooms resident wander in to deter	06/24/2026

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F0744 SS = D	Continued from page 5 R8's diagnoses included: non-Alzheimer's dementia, depression, hallucinations and a psychotic disorder other than schizophrenia. R8's behavioral symptoms Care Area Assessment (CAA) dated 4/9/26, identified R8 had worsening behaviors along with hallucinations. R8's behaviors included: isolation, pain, anxiety, hollering out, and disruptive sounds; however, did not comprehensively assess wandering or a plan to minimize it. R8's progress note dated 5/20/26, identified R8 had been wandering into three other resident's rooms tonight and had been caught by staff digging in drawers. During observations on 5/26/26 at 12:53 p.m., R8 had wandered down the south hallway and entered another resident's room. As the surveyor walked by R8 came out of the room and asked where her room was. During an interview on 5/26/26 at 1:12 p.m., R22 stated R8 came into his room and accused him of stealing her things, especially R8's dentures. "I tell her I don't need her teeth, that I have my own." R8 would call R22 "every name in the book". R8 was rummaging in R22's closet and said all R22's things belonged to R8. R22 stated R8 just kept stating "it's mine!" R22 told R8 to get out of his room and R22 was upset by what R8 said and did. R22 stated he turned on his call light but by the time staff arrived R8 had already left. R22 stated he had told staff he didn't like R8 coming into his room and they told him to turn on his call light if R8 did. [R22's quarterly MDS dated 3/11/26 identified R22 was cognitively intact.] During an interview on 5/28/26 at 8:53 a.m., registered nurse (RN)-D stated R8 did wander into other residents' rooms "from time to time". For a long time, R8 believed R22 was the doctor and would go into R22's room to talk to him. After meals, staff tried to direct her to her room. RN-D stated she did not work in the evening or night but believed R8 wandered into other rooms more frequently during that time because R8's sundowning (a state of increased confusion, anxiety, and agitation that affects people with dementia.) RN-D did not know of any interventions to prevent R8 from entering other residents' rooms. "It's just redirection." RN-D did not identify the assessment process for wandering. During an interview on 5/28/26 at 9:08 a.m., trained	F0744	Continued from page 5 them. Estimated delivery on 6/22/26. 6/23/26 Retractable belt installed on doorframe in room R22. Daughter and resident educated on the purpose and use of the belt. Per Elopement Prevention Standard Work: All residents will be assessed and behaviors reviewed by RN on admission, quarterly, and on an as needed basis to determine if additional interventions are needed to protect themselves and others. Elopement precautions will be initiated immediately for all residents deemed at high risk for elopement per the nurse's discretion based on the resident's assessments/observation. Interventions may be discontinued by RN after the IDT reviews the RNs' recommendations. A plan of preventive elopement and wandering interventions will be incorporated into the residents' plan of care. Staff Education: All staff educated in daily team huddles and through 6/22/26 weekly updates sent to all staff: Education included items added to care plan, interventions to redirect residents, and Elopement prevention standard work. All staff complete the required EduCare Dementia education annually. Upon receipt, estimated 6/22/26, staff will be educated on retractable magnetic belts for doorway to deter R8 from wandering into rooms. Monitoring & Audit Plan to Sustained Compliance: Care plans of resident RNs staff identify as residents' high risk for wandering will be audited to verify the care plan is up to date in regard to interventions related to wandering.	06/24/2026

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F0744 SS = D	Continued from page 6 medication assistant/nursing assistant (NA)-A stated R8 wandered a lot and went in and out of other residents' rooms. R8 was always easily redirected, and she would go to her room. There was nothing care planned about wandering, but staff always kept a close eye on R8 when she was out of her room. During an interview on 5/28/26 at 9:11 a.m., NA-B stated she had never seen R8 go into R22's room but had heard about it. When R8 was wandering staff just tried to keep an eye on R8 and redirect her back to her room. "I think that's all you can do." During an interview on 5/28/26 at 10:44 a.m., the social worker designee (SWD) stated at one point, R8 had entered R22's room and accused them of taking her dentures. Staff tried a lot of redirection with R8 because she was fixated on her dentures. There was no regular documentation of R8's behavior. SWD did not identify the assessment process for wandering. During an interview on 5/8/26 at 10:54 a.m., registered nurse supervisor (RN)-A stated R8 would get mixed up on where she was and would wander down the hall and enter other residents' rooms. Most of the time she was easily redirected, but other times R8 would start going through other residents' personal belongings. R8 required a lot of redirection to find her way back to her room. RN-A stated they were currently trying to always keep an eye on R8 when she was out of her room. R8's wandering should have been assessed and identified in the care plan due to being consistent behavior for her. During an interview on 5/28/26 at 11:14 a.m., the director of nursing (DON) stated resident care plans should have identified any regular resident behaviors and any interventions implemented. R8 did wander and enter into other residents' rooms and in recent months and had an escalation in wandering. R8 usually wanders right after meals, and they try to keep an eye on her and will redirect R8 back to her room. R8's should have been assessed and the care plan should have been updated to identify the wandering behavior and interventions in place. A wandering policy was requested, but it was not received.	F0744	Continued from page 6 All care plans are reviewed by IDT on admission, quarterly during care conferences, and as needed for accuracy. 5 resident care plans and documentation will be audited weekly by IDT and at reported monthly at QAPI meetings When 100% compliance has been maintained, QAPI will determine the frequency of ongoing audits. Staff responsible for the corrective actions and monitoring of compliance: Kristi Mienert RN, DON Date Corrected (all actions completed): 6/24/26 Anticipated Date of Full Compliance: 6/24/26	06/24/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F0883	Actions taken immediately to stop the deficient practice and protect residents: Education completed with RN team on up-to-date status of pneumococcal conjugate immunizations.	06/24/2026

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F0883 SS = D	Continued from page 7 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F0883	Continued from page 7 R20 & R27 reviewed with current recommendations. PneumoRec program recommended Shared Clinical Decision Making to determine need/consent for PCV20 or PCV21. Education provided to including CDC Pneumo Vaccine Timing Job Aid, CDC Shared Clinical Decision Making for PCV and PCV VIS 5/29/2025. R20 verbalized consent for PCV20 but not for a few weeks due to currently being treated for UTI. R20 vocalized desire to return to baseline prior to receiving vaccine. R27 declined any additional vaccines. R27 stated that they would not be receiving any additional vaccines. Infection prevention nurse reviewed all resident records to see if any residents needed vaccines to bring up-to-date and/or there was documentation of education with resident/family declination of vaccinations. The following measures were implemented to prevent the deficiency from recurring: New Immunization Standard Work developed to incorporate system information with specific workflows for First Care Living Center facility. RN supervisors and IP RN educated on current pneumococcal conjugate immunization recommendations, New Standard Work, how to use PneumoRec, proper documentation in admission and immunization observation, and proper documentation of consents, declinations, and delays in administering vaccinations. Staff Education: 6/15-6/19/26 RN staff completing admissions and immunization observations on: Use of PneumoRec vaccination program.	06/24/2026

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F0883 SS = D	Continued from page 8 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess pneumococcal immunization status, provide education, and document discussion and offering of pneumococcal vaccination in accordance with current CDC recommendations for 2 of 5 residents (R20, R27) reviewed for immunizations. Findings include: R20: R20's admission Minimum Data Set (MDS) dated 5/1/26, identified R20 was admitted on 4/20/26, was cognitively intact and able to make her needs known. R20's diagnoses included diabetes and hypertension. R20's Preventive Health Care Report dated 5/25/10 through 5/28/26, identified R20 received Prevnar13 on 6/17/15. R20's electronic health record failed to include evidence R20 or R20's representative received education regarding pneumococcal vaccine booster and there was no indication R20 was offered the pneumococcal vaccine per CDC guidance in conjunction with their provider. R27: R27's annual MDS dated 3/31/26 identified R27 was admitted to the facility on 3/17/26 and was 75 years old. R27's diagnoses included coronary heart disease, heart failure, and thyroid disease. The facility immunization report dated 5/28/26, identified R27 received PCV13 on 8/30/17, and PPSV23 on 11/16/18. R27's electronic health record failed to include evidence R27or R27's representative received education regarding pneumococcal vaccine booster and there was no indication R27 was offered the pneumococcal vaccine per CDC guidance in conjunction with their provider. On 5/27/26 at 1:28 p.m., registered nurse (RN)-D stated immunizations were offered upon admission and seasonally. RN-A stated she reviewed the resident's immunization status upon admission.	F0883	Continued from page 8 Process for review vaccination records, vaccination education, obtaining consent, ordering vaccination, administration, and documentation of refusals, consents, and administrations. Updated Immunization Standard Work for FCLC. Monitoring & Audit Plan to Sustained Compliance: All residents and their vaccinations will be entered on the infection prevention nurse immunization spreadsheet. Weekly audits will be completed on all new admissions and current residents to verify if any residents are due for vaccinations. Vaccination spreadsheet will be audited weekly by IP RN. Records of 25% of residents, including all new admissions, will be audited weekly using Immunization Observation Tracer. Tracer includes reviewal of vaccination observation and documentation of education, consent, and administration. Audits will be reviewed weekly by IDT and reported monthly at QAPI meetings When 100% compliance has been maintained, QAPI will determine the frequency of ongoing audits. Staff responsible for the corrective actions and monitoring of compliance: Kristi Mienert RN, DON Date Corrected (all actions completed): 6/24/26 Anticipated Date of Full Compliance: 6/24/26	06/24/2026

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F0883 SS = D	Continued from page 9 Immunizations were either administered, or a declination was signed after they were discussed with the resident and/or resident representative. On 5/28/26 at 8:53 a.m., the director of nursing (DON) stated she was uncertain what process the infection preventionist (IP) used to determine when a resident was due for the pneumococcal vaccine, although had recommended using the PnuemoRecs VaxAdvisor App or website (a standalone application that provides patient-specific guidance related to pneumococcal immunization schedule). The DON stated she was uncertain if R27 had received the most recent pneumococcal immunization. The DON stated there were no notes in the medical record identifying that the pneumococcal immunization was discussed or offered to R20 or R20's representative. Further, DON stated she expected all immunizations would be discussed with the resident and/or resident representative upon admission and per CDC guidance, as well as documenting a progress note in the resident's medical record. The Essentia Health Standard Work Process dated 3/5/26, identified staff reviewed vaccination history for all residents at the time of admission and assess if the resident needed vaccinations including pneumococcal. Staff provided and discussed the most current Vaccination Information Statement (VIS) with each resident and/or resident representative prior to administration, and document administration or declination in the resident's medical record. The CDC Pneumococcal Vaccine Recommendations dated 2/25/26 identified The United States uses 2 types of pneumococcal vaccines. Each individual vaccine helps protect against different serotypes of pneumococcal bacteria. Pneumococcal conjugate vaccines (PCVs) PCV15, PCV20 and PCV21; and Pneumococcal polysaccharide vaccine (PPSV23). Adults 50 years or older Administer PCV15, PCV20, or PCV21 for all adults 50 years or older, who have never received any pneumococcal conjugate vaccine, whose previous vaccination history is unknown. PCV15: Additional vaccination recommended If PCV15 is used, administer a dose of PPSV23A one year later. Only one dose of PPSV23 is indicated. If PPSV23 was previously administered, another dose isn't needed. The patient's pneumococcal vaccinations are complete. The minimum interval is 8 weeks and can be considered in adults with: An immunocompromising condition. A cochlear implant, A cerebrospinal fluid leak. PCV20 or PCV21: Additional vaccination not recommended If PCV20 or PCV21 is used, a dose of PPSV23 isn't indicated. Regardless of which vaccine is used (PCV20 or	F0883		06/24/2026

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F0883 SS = D	Continued from page 10 PCV21), the patient's pneumococcal vaccinations are complete. Recommendation for shared clinical decision-making: Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of 65 years old.	F0883		06/24/2026
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine;	F0887	Actions taken immediately to stop the deficient practice and protect residents: Education completed with RN team on up-to-date status of immunizations. R20 & R27 reviewed with current recommendations. Review determined R20 & R27 are due for COVID-19 vaccine. Education provided to include CDC COVID-19 VIS 01.31.2025. R20 verbalized consent for vaccines but not for a few weeks due to currently being treated for UTI. R20 vocalized desire to return to baseline prior to receiving vaccine. R27 declined any additional vaccines. R27 stated that they would not be receiving any additional vaccines. Infection prevention nurse reviewed all resident records to see if any residents needed vaccines to bring up-to-date and/or there was documentation of education with resident/family declination of vaccinations. Contacted Nords LTC pharmacy and Essentia Health pharmacy team to determine the availability of vaccines if Nords LTC pharmacy does not have supply. Verification received from Essentia Health Fosston CAH pharmacy that they have ability to order COVID-19 vaccine at any time if they do not have a supply onsite. Staff Education:	06/24/2026

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F0887 SS = D	Continued from page 11 and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to assess COVID-19 vaccination status and ensure current CDC-recommended COVID-19 vaccination was offered and documented for 2 of 5 residents (R20, R27) reviewed for immunizations. Findings include: R20: R20’s admission Minimum Data Set (MDS) dated 5/1/26, identified R20 was admitted on 4/20/26, was cognitively intact and able to make her needs known. R20’s diagnoses included diabetes and hypertension. R20's Preventative Health Care Report identified the last documented COVID-19 vaccination was administered on 11/23/21. The medical record lacked evidence the resident's COVID-19 vaccination status was assessed upon admission, that current CDC recommendations were discussed, or that the resident was offered recommended COVID-19 vaccination since admission on 4/20/26. R27: R27’s annual MDS dated 3/31/26 identified R27 was admitted to the facility on 3/17/26 and was 75 years old. R27’s diagnoses included coronary heart	F0887	Continued from page 11 6/15-6/19/26 RN staff completing admissions and immunization observations on: Process for review vaccination records, vaccination education, obtaining consent, ordering vaccination, administration, and documentation of refusals, consents, and administrations. Updated Immunization Standard Work for FCLC. Systemic Corrective Actions to prevent recurrence: On admission, quarterly, and with season changes, residents’ vaccination status will be reviewed to see if vaccinations are up to date. If COVID-19 vaccination is needed and resident/family give consent for vaccination, the vaccine will be ordered from Nords LTC pharmacy. If Nords LTC pharmacy is unable to obtain COVID-19 vaccine, Essentia Health Fosston hospital pharmacy will be contacted to obtain vaccine. Resident/family will be notified if vaccine needs to be ordered with estimated timeline for administration. Immunization Standard Work developed to integrate process for ordering vaccination and alternative sources if vaccine is unavailable from primary ordering source. Standard work includes notification of resident/family if vaccination is delayed for any reason. Monitoring & Audit Plan to Sustained Compliance: All residents and their vaccinations will be entered on the infection prevention nurse immunization spreadsheet.	06/24/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Care Living Center	900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542

(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
F0887 SS = D	Continued from page 12 disease, heart failure, and thyroid disease. R27's medical record lacked evidence staff assessed the resident's COVID-19 vaccination status upon admission, provided education regarding current CDC recommendations, offered vaccination, or obtained a documented declination. On 5/27/26 at 1:28 p.m., registered nurse (RN)-D, who is also the infection preventionist, stated immunizations were offered upon admission and seasonally. RN-A stated she reviewed the resident's immunization status upon admission. Immunizations were either administered, or a declination was signed after they were discussed with the resident and/or resident representative. On 5/28/26 at 8:53 a.m., the director of nursing (DON) stated she expected all immunizations would be discussed with the resident and/or resident representative upon admission and per CDC guidance, as well as documenting a progress note in the resident's medical record. The Essentia Health Standard Work Process dated 3/5/26, identified staff reviewed vaccination history for all residents at the time of admission and assess if the resident needed vaccinations including COVIS-19. Staff provided and discussed the most current Vaccination Information Statement (VIS) with each resident and/or resident representative prior to administration, and document administration or declination in the resident's medical record. The Centers for Disease Control 2025–2026 COVID-19 Vaccination Guidance dated 11/4/25, identified COVID-19 vaccination is recommended for all adults ages 65 years and older based on individual-based decision-making (also known as shared clinical decision-making). For people ages 6 months–64 years, vaccination is recommended based on individual-based decision-making (also known as shared clinical decision-making)—with an emphasis that the risk-benefit of vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk, according to the CDC list of COVID-19 risk factors. In addition to the CDC list, the Moderna (Spikevax) package insert states that prematurity (birth at <37 weeks gestational age) has been associated with COVID-19-related hospitalizations in children ages 6–23 months. Ages 65 years and older Unvaccinated: Administer 2 doses of 2025–2026 vaccine; Unvaccinated 2025–2026 Dose 1 (Moderna, Novavax, or Pfizer-BioNTech): Day 0 2025–2026	F0887	Continued from page 12 Weekly audits will be completed on all new admissions and current residents to verify if any residents are due for vaccinations. Vaccination spreadsheet will be audited weekly by IP RN. Records of 25% of residents, including all new admissions, will be audited weekly using Immunization Observation Tracer. Tracer includes reviewal of vaccination observation and documentation of education, consent, and administration. Audits will be reviewed weekly by IDT and reported monthly at QAPI meetings When 100% compliance has been maintained, QAPI will determine the frequency of ongoing audits. Staff responsible for the corrective actions and monitoring of compliance: Kristi Mienert RN, DON Date Corrected (all actions completed): 6/24/26 Anticipated Date of Full Compliance: 6/24/26	06/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0887 SS = D	Continued from page 13 Dose 2 (Moderna [Spikevax], Novavax, or Pfizer-BioNTech): 6 months (minimum interval 2 months) after 2025–2026 Dose 1; (Moderna [mNexspike]): 6 months (minimum interval 3 months)‡ after 2025–2026 Dose 1. Previously vaccinated before 2025–2026 vaccine: Administer 2 doses of 2025–2026 vaccine 1 or more doses any COVID-19 vaccine (Moderna, Novavax, or Pfizer-BioNTech) 2025–2026 Dose 1 (Moderna [Spikevax], Novavax, or Pfizer-BioNTech): At least 8 weeks after last dose; (Moderna [mNexspike]): At least 3 months after last dose‡2025–2026 Dose 2 (Moderna [Spikevax], Novavax, or Pfizer-BioNTech): 6 months (minimum interval 2 months) after 2025–2026 Dose 1; (Moderna [mNexspike]): 6 months (minimum interval 3 months)‡ after 2025–2026 Dose 1.	F0887		06/24/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 11, 2026

Administrator
First Care Living Center
900 HILLIGOSS BOULEVARD SOUTHEAST
FOSSTON, MN 56542

RE: CCN:245512

Cycle Start Date: May 28, 2026

Dear Administrator:

On May 28, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 August 28, 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 November 28, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division

445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NURSING HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Care Living Center	**900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542**

(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 recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/26/2026. At the time of this survey, First Care Living Center / Essentia Health Fosston 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		06/18/2026

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: 245512	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NURSING HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Care Living Center	**900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Essentia Health NH is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(111) construction. In 1997, additions to the sleeping rooms and an activates room to the north east corner were constructed. Theses additions are Type II(111) construction. The building is divided into 4 smoke zones with a 30 minute and two 2-hour fire barriers. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems . The facility has a fire alarm system with smoke detection in the corridor system, in all sleeping rooms and in common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" . The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system. The facility has a capacity of 50 beds and had a	K0000		06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NURSING HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

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K0000 Bldg. 01	Continued from page 2 census of 47 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		06/18/2026
K0232 SS = F Bldg. 01	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the minimum width and clear, unobstructed egress corridor per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, 19.2.3.5, 7.5.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/26/2026 at 2:39pm it was revealed by observation that the egress corridor leading from the therapy room did not maintained with a clear width of 48 inches required for this type of facility. Staff had stored equipment on both sides of the corridor and blocked the exit door. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0232	The following actions were taken to correct the deficiency: Removed all items blocking path for egress on 05/26/2026 The following measures were put in place to ensure the deficiency does not reoccur: Educate maintenance and Skilled Nursing Facility staff of the regulation and need to maintain the egress path Walkthroughs will initially be performed to ensure compliance The facility will monitor the following to ensure solutions are sustained: Visual inspection of egress path in the Skilled Nursing Facility via walk throughs Inspection results will be documented on the Egress Path Inspection Sheet Weekly for 3 months if compliance threshold is met (if the threshold is not met, checks will be extended for an additional 3 months). Staff responsible for the corrective actions and monitoring of compliance: Kraig Kubiak Date Corrected: 6/18/2026 Date of Full Complaince: 5/26/2026	06/18/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K0761	The following actions were taken to correct the deficiency: Contacted W.L. Hall to recertify the door frame, they	07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NURSING HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

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K0761 SS = F Bldg. 01	Continued from page 3 Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/26/2026 at 12:17pm, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0761	Continued from page 3 will be here on 07/07/2026 to recertify the door The following measures were put in place to ensure the deficiency does not reoccur: Updated the annual door inspection form to include verification of door labels are present on fire rated doors Recently obtained certification for an additional maintenance staff member to expand the number of individuals who can perform the annual inspection Staff educated on: Ashe Fire door inspection and maintenance class certification class on 5/18/26. In person meeting on updated fire door inspection sheet on 6/4/26. The facility will monitor the following to ensure solutions are sustained: Visual inspection of the fire door tags. Compliance tracker for notification of date of inspection Updated fire door inspection sheets Compliance tracker will be reviewed weekly on an ongoing basis for notifications of upcoming certifications Annual visual confirmation of updated fire door inspection sheet for 1 year Staff responsible for the corrective actions and monitoring of compliance: Kraig Kubiak	07/07/2026

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K0761 SS = F Bldg. 01		K0761	Continued from page 4 Date Corrected (all actions completed): 6/4/26 Anticipated Date of Full Compliance: 7/7/26	07/07/2026
K0291 SS = E Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.9.1 and 7.9.1.3. This deficient practice could have a patterned impact on the residents within the facility. Findings include: On 05/26/2026 at 12:16pm, it was revealed by observation that the facility failed to conduct the annual 90 minute required Emergency Lighting test. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0291	The following actions were taken to correct the deficiency: The annual 90 minute required Emergency Lighting test was completed on 5/26/2026. The following measures were put in place to ensure the deficiency does not reoccur: Schedule was updated to be completed on 12 month intervals. Inspection sheets were adjusted to indicate the annual test is due in May from here on. The staff were instructed if they do it early, they must continue that from then on, must be every 12 months. All maintenance staff were educated on how to complete the testing. The facility will monitor the following to ensure solutions are sustained: Compliance tracker for notification of date of inspection Visual confirmation of updated inspection sheet for testing. Compliance tracker will be reviewed weekly on an ongoing basis Visual review of updated inspection sheet for testing will be completed monthly for 1 year Staff responsible for the corrective actions and monitoring of compliance: Kraig Kubiak	06/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NURSING HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

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K0291 SS = E Bldg. 01		K0291	Continued from page 5 Date Corrected (all actions completed): 6/23/2026 Anticipated Date of Full Compliance: 5/26/2026	06/23/2026
K0324 SS = D 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 * 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 documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 05/26/2026 at 12:43pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection	K0324	The following actions were taken to correct the deficiency: Contracted inspection company completed the inspection on 02/23/2026 (currently in compliance, but this was several months late) The following measures were put in place to ensure the deficiency does not reoccur: Implementing compliance tracker for monitoring and notification of upcoming inspections This will trigger onsite staff to confirm completion of inspection Staff educated on Semiannual inspection and compliance tracker during staff meeting on 6/9/26 The facility will monitor the following to ensure solutions are sustained: Monitoring inspection completion. Compliance tracker will be reviewed weekly on an ongoing basis Semiannual visual confirmation of completion of inspection will be completed monthly for a period of 12 months Staff responsible for the corrective actions and monitoring of compliance: Kraig Kubiak Date Corrected (all actions completed): 6/23/2026 Anticipated Date of Full Compliance: 2/23/2026	06/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NURSING HO...** B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Care Living Center	**900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542**

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K0324 SS = D Bldg. 01	Continued from page 6 documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0324		06/23/2026
K0355 SS = D 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 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/26/2026 at 12:14pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0355	The following actions were taken to correct the deficiency: The fire extinguisher inspection was completed on 5/26/26. The following measures were put in place to ensure the deficiency does not reoccur: Changed the workflow to match regulations (sign off on month of inspection) Educated staff on new workflow Updated fire extinguisher inspection sheets on 6/18/26 to mirror workflow change Implementing compliance tracker for monitoring and notification. Staff have been instructed that a staff member or inspector of the fire extinguishers are required to sign off on all extinguishers monthly (including the month the inspector of the fire extinguisher reviews them) at meeting on 5/26/26 The facility will monitor the following to ensure solutions are sustained: Compliance tracker for notification of date of inspection Visual conformation of updated fire extinguisher inspection sheet. Compliance tracker will be reviewed weekly on an ongoing basis	06/23/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Care Living Center	**900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542**

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K0355 SS = D Bldg. 01		K0355	Continued from page 7 Visual review of updated fire extinguisher inspection sheet will be completed monthly for a period of 6 months Staff responsible for the corrective actions and monitoring of compliance: Kraig Kubiak Date Corrected (all actions completed): 6/23/26 Anticipated Date of Full Compliance: 5/26/26	06/23/2026
K0372 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a isolated impact on the residents within the facility. Findings include: On 05/26/2026 at 1:37pm, it was revealed by observation that there was a penetration running from one smoke compartment to another in the wall in the medical supply room. An interview with the Director of Maintenance	K0372	The following actions were taken to correct the deficiency: Caulking was added to the identified pipes to repair the penetration for smoke barrier integrity on 06/01/2026 The following measures were put in place to ensure the deficiency does not reoccur: Maintenance will inspect all projects involving access to smoke barriers to verify that the smoke barriers are intact. Implemented a restricted access permit: The contractor will have to show staff members the path they are going to take and a map. When the job is completed, they will have to prove to maintenance they fire caulked smoke barrier penetrations. During 5/27/26 meeting, maintenance staff educated on: Proper way to apply fire caulking to smoke barrier penetrations The use of the restricted access permit	06/01/2026

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K0372 SS = D Bldg. 01	Continued from page 8 verified these deficient findings at the time of discovery	K0372	Continued from page 8 The use of the restricted access permit will monitor the penetrations for proper fire caulking. The facility will monitor the following to ensure solutions are sustained: Caulking of smoke barrier penetrations Restricted access permit to monitor smoke barrier penetrations for proper fire caulk. Caulking with be visualized: before, during, and after contractors have completed a job. Staff responsible for the corrective actions and monitoring of compliance: Kraig Kubiak Date Corrected (all actions completed): 6/1/26 Anticipated Date of Full Compliance: 6/1/26	06/01/2026