Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 10, 2026

Administrator
Belgrade Nursing Home
103 SCHOOL STREET
PO BOX 340
BELGRADE, MN 56312

RE: CCN:245418
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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING B. WING	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belgrade Nursing Home	103 SCHOOL STREET PO BOX 340, BELGRADE, Minnesota, 56312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 5/26/26 thru 5/28/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H (MN). NO deficiencies were cited. H 54187711C H54187711c with Associate FRI 279432 H54182581C H54182584C The facility is enrolled in ePOC, 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, the facility must acknowledge receipt of the electronic documents.	E0000		06/12/2026
F0000	INITIAL COMMENTS On 5/26/26 thru 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 following complaints were reviewed: H (MN). NO deficiencies were cited. H 54187711C H54187711c with Associate FRI 279432 H54182581C H54182584C The facility is enrolled in ePOC, therefore a signature	F0000		06/12/2026

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: 245418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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F0000	Continued from page 1 is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F0000		06/12/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F0880	On 6/12/2026, Director of Nursing reviewed the handwashing policy and procedure with NA-A. NA-A was reeducated and properly demonstrated back handwashing procedure. On 5/29/26, Director of Nursing completed three hand hygiene audits of certified nursing assistants. Audit revealed 100% compliance with hand hygiene and glove use. Director of Nursing or Designee will continue monthly hand hygiene audits. Director of Nursing or Designee will continue to report quarterly finds to the Quality Assurance and Performance Improvement Committee.	06/12/2026

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F0880 SS = D	Continued from page 2 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed while providing morning cares for 1 of 3 residents (R8) when observed. Findings include: R8's significant change Minimum Data Set dated 4/29/26, indicated diagnosis of dementia. During an observation on 5/28/26 at 7:29 a.m., nursing assistant (NA)-A got clothing out that R8 wanted to wear. NA-A assisted R8 to the wheelchair and took R8 to the bathroom. NA-A put on clean gloves and took down R8's pants. R8 sat down on the toilet. NA-A put on clean underwear, pants and socks. NA-A gave R8 a wet cloth to wash the face and R8 dried the face. NA-A removed R8's soiled brief and took soiled gloves off. NA-A put on clean gloves on and removed R8's shirt and washed arm pits, dried them, put on R8's deodorant. NA-A took	F0880		06/12/2026

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F0880 SS = D	Continued from page 3 off the soiled gloves and put on R8's shirts. NA-A put on clean gloves and had R8 stand to wipe the bowel moment from R8's bottom. R8 sat down on toilet. NA-A removed her soiled gloves and put on new gloves. R8 stood up and NA-A washed R8's peri area with a soapy washcloth and dried the area. NA-A pulled up R8's brief, underwear and pants. R8 sat in the wheelchair. NA-A removed the soiled gloves and brushed R8's hair. NA-A put clean gloves on and cleaned R8's dentures and gave to R8 to place in her mouth. NA-A took soiled gloves off and tied up the garbage bag. R8 requested a hat and NA-A got one for R8. NA-A straightened up the bed then gave R8 her glasses. NA-A brought R8 to be weighed then brought the garbage to the soiled room and placed bag in the bin. NA-A then brought R8 to the dining room for breakfast. During an interview on 5/28/26 at 7:58 a.m., NA-A stated she should change gloves when soiled or have body fluids on the gloves. NA-A stated you washed your hands after the bathroom use, after toileting the residents, and after feeding the residents. NA-A stated she washed her hands whenever. NA-A stated she was supposed to wash hands or us hand sanitizer. NA-A stated I do not know why I did not wash my hands or use hand sanitizer after removing gloves today. During an interview on 5/28/26 at 11:34 a.m., the director of nursing (DON) stated hand hygiene should be completed when taking gloves off, before and after care, before and after passing trays, before and after meals, and when donning and doffing of personal protective equipment (PPE). The DON stated hand hygiene audits were completed monthly and staff are retrained in the moment when not doing appropriate hand hygiene. At 11:39 a.m., the DON stated the NA should have been following the policy and procedure for hand hygiene. The DON stated appropriate hand hygiene should have been completed when the NA removed her gloves. The facility policy Handwashing reviewed 5/28/26, indicated hand hygiene is considered the single most important procedure for preventing health care associated infections. Bacteria are easily spread in the hospital environment from patient to patient via the hands of healthcare workers. Any contact with the patient or the patient's environment could conceivably result in the transfer of microorganisms to the hands. Following standard precautions and avoiding contamination of the hands is essential in	F0880		06/12/2026

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F0880 SS = D	Continued from page 4 helping to prevent the spread of microorganisms. The policy indicated wearing gloves is not a substitute for hand hygiene. Dirty gloves can soil hands. Disposable gloves should be used only once and may not be washed for reuse. Always clean your hands after removing gloves.	F0880		06/12/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 05/27/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Belgrade Nursing Home 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		06/12/2026

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

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was surveyed as one building: Belgrade Nursing Home is a 1-story building with no basement. The building was constructed at 5 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1968, an addition was added to the north that was determined to be of Type II(111)construction. In 1981 an addition was added to the north of the East Wing that was determined to be of Type II(111) construction. In 1987 an addition was added to the south and east of the original building that was determined to be of Type V(111). In 1988 the Dining Room and Kitchen were added on to that was determined to be of Type V(111) construction. In 2013 an PT addition was added to the south west corner of the building that was determined to be of Type II(111) construction. Because of the lack of 2 - hour fire resistive construction between the Type V(111) constructed 1987 & 1988 additions to the Type II(111) constructed Original building and the 2013 PT addition, the	K0000		06/12/2026

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K0000 Bldg. 01	Continued from page 2 building construction type is downgraded to Type V(111). The building is protected by a complete fire sprinkler system and also has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 34 beds and had a census of 23 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		06/12/2026
K0346 SS = F Bldg. 01	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on review of available documentation and staff interview, the facility failed to implement a fire watch policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 05/27/2026 at 9:28 AM, it was revealed by a review of available documentation that the Fire Watch Policy for when the Fire Alarm System is out of service did not indicate that whoever is assigned to do Fire Watch should have no other duties assigned to them. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0346	On 5/27/2026, the “Fire Sprinkler System – Out of Service” policy and procedure and the “Fire Watch Log” was updated to include language “the fire watch personnel will have no other duties assigned to them while the fire protection system is out of service”. Updated policy/procedure and log were reviewed at the Department Head Meeting on 6/8/2026. Also, the updated policy/procedure and log will be reviewed at the next Safety Committee Meeting.	06/23/2026
K0351 SS = F Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101	K0351	On 5/27/2026, following the Fire Marshall’s recommendation, Maintenance Director install a Lock Out/Tag Out lock on the air compressor plug in cover to prevent tampering and loss of power to the	06/12/2026

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K0351 SS = F Bldg. 01	Continued from page 3 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 7.2.6.2.1. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 05/27/2026 at 10:20 AM, it was revealed by observation that air compressor for the dry sprinkler system was plugged into a wall outlet and not secured to prevent the loss of power to the compressor and air pressure in the system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0351	Continued from page 3 compressor and air pressure in the Dry Sprinkler Systems. On 6/12/26, the Safey Officer added a line entry to the Automatic Sprinkler System inspection log to ensure the lock remains in place. Maintenance Director or Designee will report monthly findings to the Quality Assurance and Performance Improvement Committee.	06/12/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K0353	On 1/13/26, Safety Officer identified non-compliance of the quarterly Fire Spinkler Inspection in the third and fourth quarter of 2025. After identifying the deficient practice, a contract was put in place with local vendor to complete the quarter Fire Sprinkler Inspections. Sprinkler System Inspection was completed on 2/4/26 and 5/4/26 which put the facility back in compliance. The sprinkler head in laundry which was identified as showing signs of loading with lint and debris will be cleaned by the Sprinkler System vendor due to the sensitivity of the system which will include	07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245418	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belgrade Nursing Home	**103 SCHOOL STREET PO BOX 340, BELGRADE, Minnesota, 56312**

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K0353 SS = F Bldg. 01	Continued from page 4 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.2.1.1.2(5). These deficient findings could have a widespread impact on residents within the facility. Findings include: On 05/27/2026 at 9:45 AM, it was revealed by a review of available documentation that the facility could not provide documents showing that quarterly fire sprinkler inspections were conducted in the 3rd and 4th quarters of 2025. On 05/27/2026 at 10:32 AM, it was revealed by observation that the sprinkler head behind the two industrial clothes dryers in the main laundry room was showing signs of loading with lint and debris. On 05/27/2026 at 10:35 AM, it was revealed by observation that the outside horn and strobe indicating waterflow in the building was covered in a birds nest. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0353	Continued from page 4 training to the maintenance director for identifying and cleaning sprinkler heads on 6/22/26. A facility wide sprinkler head visual inspection was completed on 6/11/26 resulting in no additional sprinkler head loading with lint and debris. This visual inspection was completed quarterly by the Maintenance Director or Trained Designee. On 5/28/26, Maintenance Director removed the bird’s net from the outside horn and strobe. On 6/12/26, the Safey Officer added a line entry to the Automatic Sprinkler System inspection log for a visual inspection of the outside horn and strobe light which is completed monthly. Maintenance Director or Designee will report monthly findings to the Quality Assurance and Performance Improvement Committee.	07/03/2026
K0500 SS = D Bldg. 01	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 18.5	K0500	On 6/8/26, the Maintenance Director replaced the plastic dry vent hose with a non-compatible dry vent hose.	06/08/2026

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K0500 SS = D Bldg. 01	Continued from page 5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain building services per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1, and 9.2.2, and NFPA 91 (2010 edition), Exhaust Systems for Air Conveying of Vapors, Gases, Mists, and Noncombustible Particulate Solids, section 4.2.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/27/2026 at 10:22 AM, it was revealed by observation that the flexible dryer vent duct connected to dryer in the small laundry room was not made with noncombustible material. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0500		06/08/2026
K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors 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 observation and staff interview, the facility failed to maintain fire doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, and 4.6.12, and NFPA 80 (2010 edition), Standard for Fire Doors	K0761	On 5/28/2026, the Maintenance Director adjusted the door closure between the nursing home and apartments to ensure proper latch of the doors where no gap is visible. Maintenance Director will inspect all fire doors to ensure proper latch and no gaps. Maintenance Director or Designee will report findings to the Quality Assurance and Performance Improvement Committee.	07/03/2026

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K0761 SS = D Bldg. 01	Continued from page 6 and Other Opening Protectives, sections 5.1.3.1, and 5.1.5.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/27/2026 at 10:23 AM, it was revealed by observation that the fire door between the Nursing home and the apartments did not properly latch at the top of the door leaving a gap between the door leaves. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0761		07/03/2026