DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 13, 2026

Administrator
St Therese Of Woodbury LLC
7555 BAILEY ROAD
WOODBURY, MN 55129

RE: CCN: 245632

Cycle Start Date: May 29, 2026

Dear Administrator:

On June 16, 2026, we notified you a remedy was imposed. On July 2, 2026 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 2, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 1, 2026 be discontinued as of July 2, 2026. (42 CFR 488.417 (b))

In our letter of June 16, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 1, 2026. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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June 16, 2026

Administrator
St Therese Of Woodbury LLC
7555 BAILEY ROAD
WOODBURY, MN 55129

RE: CCN: 245632
Cycle Start Date: May 29, 2026

Dear Administrator:

On May 29, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 1, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 1, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2026.

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by July 1, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, [Facility Name()] will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 1, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division

Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 29, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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: 245632	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Therese Of Woodbury Llc	7555 BAILEY ROAD , WOODBURY, Minnesota, 55129

(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 to 5/29/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was NOT 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		06/23/2026
F0000	INITIAL COMMENTS On 5/26/26 through 5/29/26, 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 complaint was reviewed: H56322374C (3011906). NO deficiencies were cited. The following complaint was reviewed: H56322562C (3015735) with a deficiency cited at F689. 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		06/23/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	During the annual survey, the facility added R61's Speech-Language Pathologist (SLP) orders to the resident's care plan, which updates the Nursing Assistant Registered (NAR) Kardex. The facility also attached the notes to the resident's care profile so	06/29/2026

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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F0689 SS = G	Continued from page 1 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe use of a wheelchair without foot pedals and added cushions was assessed for 1 of 2 residents (R28) reviewed for falls. This resulted in actual harm when R28 fell from the wheelchair during transport, sustained a right leg fracture and required hospitalization. The facility had implemented actions to prevent recurrence prior to survey on 5/26/26, therefore the citation was issued at past noncompliance. Furthermore, the facility failed to provide supervision with meals for 1 of 1 resident (R61) reviewed for nutrition. Findings include: R28's quarterly Minimum Data Set (MDS) dated 3/9/26, identified that R28 was cognitively intact and had diagnoses of peripheral vascular disease, hallucinations, fractures of the second and third lumbar vertebrae, heart failure, obesity, muscle weakness, and osteoarthritis. The MDS further identified that R28 was dependent on staff for transfers and mobility and was transported in a wheelchair. R28's activities of daily living (ADL) Care Area Assessment (CAA), dated 9/7/25, identified that R28 required extensive assistance with upper and lower body dressing and rolling in bed. R28 was dependent on staff for footwear management, sit-to-lying and lying-to-sit transitions, sit-to-stand activities, and chair-to-bed transfers. R28's fall CAA dated 9/7/26, indicated R28 was at risk for falls related to a history of falls, high risk medications and weakness. R28's care plan dated 3/19/26, identified the following: -R28 had an ADL deficit. Interventions included R28 did not ambulate, required assistance from two staff members for bed mobility, bathing, and toilet	F0689	Continued from page 1 nurses can review the special eating instructions and ensure all staff are aware. R61 has since been upgraded to be able to eat independently without supervision by SLP. Audit was conducted on all residents to review for specific SLP instructions regarding supervision, feeding assistance, etc. Care plans and Kardex updated as needed to reflect SLP instructions. Admissions personnel to review orders when received and to notify Nurse Managers email group of any SLP Instructions, staff members who complete admissions were educated on the updated process. Director of Nursing or designee will monitor and report to QA/QAPI until significant compliance is met. Audits to be conducted on all new admissions for 2 months for SLP Instructions/Orders. Director of Nursing or designee will monitor and report to QA/QAPI until significant compliance is met.	06/29/2026

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F0689 SS = G	Continued from page 2 hygiene. R28 required a mechanical lift with assistance from two staff members for transfers. -R28 was at risk for falls related to a history of falls, wheelchair dependence, oxygen tubing, increased weakness, incontinence, and increased assistance needs with mobility. Interventions included use of safe footwear, maintaining the bed in the lowest position, and ensuring the call light remained within reach. R28's care plan lacked intervention or instruction regarding foot pedal use or the placement of cushions in the wheelchair. A nursing progress note dated 5/15/26 at 1:59 p.m., indicated R28 fell forward from the wheelchair while being pushed down the hallway to the weight room. R28 landed on the floor on their right side. R28 had abrasions to the right forehead and right knee and complaints of right leg pain. A nursing progress note dated 5/15/26 at 2:32 p.m., indicated R28 was transported by emergency medical services at approximately 11:30 a.m. due to the fall with right-sided pain. R28's fall incident report dated 5/15/26, indicated she was transferred to the emergency room, had an x-ray which indicated fracture of the right distal femur (upper leg), she was admitted for surgery. The root cause indicated R28 was being pushed in the wheelchair and fell out. R28's medical record lacked indication R28 had been assessed for cushion use in her wheelchair. R28's medical record lacked indication R28 refused foot pedal use during transport or an assessment for safe wheelchair transportation with no foot pedals. During an interview on 5/28/26 at 9:18 a.m., Nursing Assistant (NA)-B stated that R28 disliked the foot pedals and often refused to use them. NA-B stated that R28 could hold her legs up during transport. NA-B further stated footrests were not required for residents who propelled themselves; however, R28 was unable to self-propel. During an interview on 5/28/26 at 9:37 a.m., Licensed Practical Nurse (LPN)-C stated she was on duty at the time of R28's fall. LPN-C reported hearing a thud and finding R28 on the floor lying on her right side. LPN-C performed neurological checks, range-of-motion assessments, and vital sign monitoring. LPN-C stated that NA-G had been	F0689		06/29/2026

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F0689 SS = G	Continued from page 3 pushing R28 in the wheelchair, the foot pedals were resting on R28's lap, and a cushion had been positioned behind R28's back. LPN-C stated R28 could not self-propel and required foot pedals for support. LPN-C further stated that the additional cushions required an evaluation for safety before use. During an interview on 5/28/26 at 10:06 a.m., Physical Therapist (PT)-A stated the assessment for footrest use was based on leg strength. PT-A stated R28 could hold her legs elevated during transport and reported observing R28 perform this task without difficulty. PT-A acknowledged performing strength assessments but stated there was no documentation demonstrating that R28 had been assessed for the safe transport without using foot pedals. PT-A also verified R28's medical record lacked documentation regarding R28's refusal of foot pedals and any associated risks or benefits. During an interview on 5/28/26 at 10:38 a.m., NA-G stated he was pushing R28 to the weight room while carrying her oxygen tank. He stated the foot pedals were on R28's lap and R28 lifted her legs during transport. NA-G reported a cushion approximately four inches thick had been positioned in the wheelchair behind R28's back. NA-G was unaware if the cushion had been assessed or approved for wheelchair use. NA-G verified there were no instructions in the electronic medical record regarding the use of cushions or foot pedals. NA-G further stated the foot pedals were in R28's lap so they could be put on after obtaining her weight to transport to the beauty salon. During an interview on 5/28/26 at 11:59 a.m., the Director of Nursing (DON) stated the facility did not have a specific policy regarding foot pedal use. The DON stated that cushions placed in wheelchairs should comply with manufacturer recommendations and that any modification to the wheelchair needed to be evaluated for safety. The DON further stated the facility's investigation for R28’s fall identified both decreased seating space and the absence of foot pedals as contributing factors to the fall. During an interview on 5/28/26 at 12:22 p.m., Family Member (FM)-B stated she had not witnessed the incident. FM-B reported being informed that R28 had been transported without foot pedals while being taken to be weighed and then to the beauty salon. FM-B stated that R28 occasionally did not use foot pedals and could hold her legs up. However, she had been told that during this incident R28's right foot dropped to the floor, causing R28 to fall forward	F0689		06/29/2026

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F0689 SS = G	Continued from page 4 from the wheelchair. FM-B stated that R28 required surgery to the right leg and was still in the intensive care unit and required ventilator (breathing) support. FM-B stated she had provided the cushion from home because R28 complained of back discomfort. FM-B stated that R28 sat on one cushion and had another cushion positioned behind her back. During a follow up interview on 5/28/26 at 3:05 p.m., PT-A stated he was unaware of the origin of the cushion and had not assessed its safety for wheelchair use. PT-A did not document any assessment or discussion regarding the cushion in the medical record. During an interview on 5/28/26 at 3:05 p.m., the Rehabilitation Manager (DRS) stated assessment for foot pedal use was based on the resident's ability to perform lower body dressing tasks. DRS acknowledged that R28 was unable to self-propel. DRS stated that R28 reportedly refused foot pedals because they were uncomfortable. However, verified R28's medical record lacked documentation of assessment, care plan, or interventions addressing foot pedal use. During an interview on 5/28/26 at 3:31 p.m., Registered Nurse (RN)-H stated that cushions or pillows should not be added to wheelchairs without a safety assessment. RN-H stated that when a resident refused foot pedals, staff should assess the situation, notify the provider, obtain appropriate orders, and implement interventions through the care plan and Kardex. During an interview on 5/28/26 at 3:57 p.m., Nurse Practitioner (NP)-B stated residents should be assessed before cushions were added to wheelchairs and any modification to an assistive device required a safety evaluation. NP-B stated foot pedals resting on a resident's lap constituted improper use and that foot pedals should remain attached to the wheelchair to reduce the risk of injury and falls. NP-B stated that the improper use of foot pedals and lack of safety assessment for the cushion use were factors that contributed to R28's fall. During a follow up interview on 5/29/26 at 9:26 a.m., the DON expected cushion use in wheelchairs to be assessed and approved for safety prior to use. The DON stated that cushions could alter seating position, reduce available seating space, and could shift the resident's center of gravity, and increase the risk of falls and injuries. Furthermore, DON expected any refusals to be documented and to be	F0689		06/29/2026

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F0689 SS = G	Continued from page 5 for interventions or education to be care planned. The facility policy titled "Use of Assistive Devices," dated 1/26, stated that assistive devices were to be used consistently and appropriately based on the resident's comprehensive assessment and implemented in accordance with the resident's care plan. The past noncompliance began on 5/15/26. The deficient practice was corrected by 5/22/26, and prior to survey after the facility implemented a systemic plan that induced the following actions: immediate education on use of leg rests when transporting residents in wheelchairs and modification of wheelchairs from cushions or pillows for all NA's and nurses, health unit coordinators, managers and directors, an audit of residents who use wheelchairs for mobility to determine their ability to self-propel and when leg rests should be used, and an audit of wheelchairs used for residents to determine if cushions or other modifications were assessed for safe use. Observations of safe wheelchair transports were observed during survey, and staff education, audits, and care plans reviewed to determine compliance. R61 R61's admission MDS was in progress. R61's hospital Discharge Summary dated 5/23/26, identified on 5/20/26, R61 had an episode of shortness of breath, oxygen was required, and a chest x-ray was obtained to see if he aspirated. R61 would discharge to a transitional care unit (TCU) and discharge orders for swallowing instructions identified full supervision and assistance with all PO (by mouth). R61's hospital progress notes dated 5/22/26, identified the chest x-ray for questionable aspiration was negative for any infiltrate. Plan was to monitor. R61's facility nursing Admission Assessment dated 5/23/26, identified a diagnosis of unstable fracture of the first cervical vertebra. R51 was alert and oriented to person, place, time and situation and always required an Aspen collar (rigid orthotic device worn around the neck to immobilize the cervical spine) on due to cervical fracture. No mealtime supervision was identified. R61's facility diet order dated 5/23/26, identified full supervision and assistance with all PO.	F0689		06/29/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 6 R61's facility activities of daily living (ADL) care plan dated 5/23/26, identified set up and clean up assistance was required for eating. No mealtime supervision was identified. R61's Kardex (nursing assistant care guide with interventions pulled from the care plan) printed 5/26/26, identified set up and clean up assistance was required for eating. No mealtime supervision was identified. R61's facility diet order had not been pulled into the care plan or the Kardex for staff to be aware of the order. R61's facility speech language pathologist (SLP) recommendations progress note dated 5/26/26 at 9:53 a.m., identified "resident must be supervised during oral intake due to aspiration risk." R61's Point of Care (POC) charting dated 5/23/26 through 5/26/26, identified no mealtime supervision was provided. During an observation on 5/26/26 at 12:06 p.m., R61's was not in his room, and his lunch was on the tray table in his room. At 12:07 p.m., physical therapist (PT)-B brought R61 into his room, moved the bedside table in front of him and set up his meal. PT-B placed an instruction sheet in front of R61 which identified: Sit upright while eating and drinking Eat at a slow rate Take one small bite at a time and chew well Wash down every bite with a small drink Swallow multiple times for each bite drink Brush teeth after meals No mealtime supervision was identified. During an observation and interview on 5/26/26 at 12:11 p.m., R61was seated in his wheelchair with his Aspen collar on. He stated he broke his neck and	F0689		06/29/2026

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F0689 SS = G	Continued from page 7 had some trouble swallowing now. They thought he aspirated in the hospital, but he was not sure if he had, so the instruction sheet provided him with some safe swallowing techniques. R61 was asked if he wanted to eat in the dining room and he said it did not matter to him. R61 began to eat his meal. The way R61 was seated in his room, he was not visible to anyone walking past his room due to being seated closer to the bathroom and not in the entrance hallway to his room. A continuous observation started at this time. -At 12:34 p.m., several intermittent unidentified staff walked past the room, no one had gone in to provide supervision. -At 12:46 p.m., no staff entered the room to provide supervision. Several staff in scrubs continue to walk past the room and no one has gone in to provide supervision. -At 12:48 p.m., NA-C walked past R61's room. When asked, she stated most of the residents eat their meals in their rooms and she was not aware of anyone with risk of aspiration or who required supervision during meals. NA-C stated the nurse would tell the NA's residents which needed supervision. NA-C verified on R61's Kardex that he did not require supervision during meals. -At 12:53 p.m., surveyor entered R61's room. He had eaten half of a taco, his side dish. R61 stated he could not remember if anyone told him he needed mealtime supervision. -At 1:02 p.m., NA-D walked past R61's room. When asked she stated R61 ate breakfast independently in his room this morning. NA-D stated the nurse would tell the NA's which residents needed supervision during meals and she was not aware of anyone with this requirement. Supervision was defined as someone close by that could see the resident. NA-D stated R61 was independent with eating in his room. -at 1:09 p.m., SLP walked past R61's room and the continuous observation ended. When asked she stated R61's facility admission orders had not identified supervision with meals, and she added that to the order. She stated she would send an email with any orders to the nursing staff and try to update the NA's verbally on the mealtime supervision, however, had not done that right away as she had another patient appointment to get to. After nursing received the email, they would update the resident plan of care. SLP stated supervision meant R61 should eat in the commons area, out of	F0689		06/29/2026

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F0689 SS = G	Continued from page 8 his room) where staff could supervise due to his risk of choking. Ideally, the order would be implemented immediately. During a follow up observation on 5/26/26 at 5:40 p.m., R61 was in the dining room for his meal with staff supervision. During an interview on 5/26/26 at 5:43 p.m., NA-E stated she was updated by the nurse that R61 required mealtime supervision in the dining room. She would also consult the Kardex for resident care questions. During an interview on 5/26/26 6:03 p.m., registered nurse (RN)-B stated admission orders were verified by two nurses and reviewed by the supervisor. During an interview on 5/26/26 at 6:06 p.m., RN-C stated admission orders were verified by two nurses. During a follow up interview on 5/27/26 at 9:01 a.m., NA-B stated yesterday R61's Kardex had not identified the order for mealtime supervision, however, today the Kardex was updated and the nurse updated her as well, that R61 required mealtime supervision out in the commons area in the dining room where he could be watched. During a follow up interview on 5/27/26 at 9:10 a.m., NA-C stated she was updated by the nurse that R61 required mealtime supervision and needed eyes on him during eating such as in the dining room. R61 should not have meals in his room unsupervised. During an interview on 5/27/26 at 10:57 a.m., RN-E stated she entered R61's admission orders. The root cause of staff not being aware of the mealtime supervision order from the hospital was because the way the order was entered, it did not pull through to the Kardex or care plan so staff could be aware. RN-E stated she would expect orders to be entered in a way that is visible to the staff caring for the residents. RN-E stated there could be a risk of choking because R61's order was not entered correctly. During an interview on 5/27/26 at 10:31 a.m., RN-A stated she was the manager and would review admission orders, history and physicals, and update the care plan within 72 hours and ensure accuracy. RN-A verified R61's hospital orders for mealtime supervision due to risk of aspiration. RN-A verified R61's facility admission assessment lacked indication for mealtime supervision, therefore that	F0689		06/29/2026

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F0689 SS = G	Continued from page 9 intervention had not pulled into the care plan or Kardex for staff to be aware. RN-A verified the order should have been entered in the computer in a way that the staff caring for the residents were aware of the mealtime supervision, the way the order was entered into the medical record was not initially correct. During an interview on 5/27/26 at 11:57 a.m., license practical nurse (LPN)-B stated she helped enter R61's admission orders. For residents that require mealtime supervision, that should pull through on the toe treatment administration record (TAR), care plan and Kardex. LPN-B was not aware of any issues with the order transcription yet. LPN-B stated she was not able to observe R61 at mealtimes when he was admitted, and that he ate his evening meal in his room without supervision. During an observation on 5/27/26 at12:19 p.m., R61 was seated in the dining room with supervision for his noon meal. During an interview on 5/27/26 at 12:20 p.m., R61's family member (FM)-A stated while in the hospital R61 had swallowing issues because of his neck fracture and having to wear the Aspen collar during meals. FM-A stated it was hard to eat when a person cannot open their mouth all the way. During an interview on 5/27/26 at 1:37 p.m., the DON stated two nurses would check admission orders for accuracy. Mealtime supervision orders should be entered in a way they pull through to the care plan and Kardex so the staff caring for the residents would be aware. After the SLP noticed the order transcription error, she updated nursing and the order was corrected. The DON stated the way the order was initially entered, not all staff could see it clearly. The DON stated he expected orders to be entered correctly and to reach the appropriate staff caring for the residents. The DON stated R61 would potentially be at risk of choking without mealtime supervision. During an interview on 5/27/26 at 2:19 p.m., R61's NP-A stated he was at moderate to high risk of aspiration since he had an order for full supervision at mealtimes. NP-A stated when she did her admission visit with R61 on 5/26/26, he had no respiratory concerns, and she noted he was eating 50-100% of his meals. NP-A stated his choking risk was related more so to the Aspen collar needing to be on at mealtimes. He has been eating 50-100%. NP-A stated she would expect admission orders to be entered accurately.	F0689		06/29/2026

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F0689 SS = G	Continued from page 10 The facility's Meal Supervision and Assistance policy dated 1/2026, identified the resident will be prepared for a well-balanced meal in a calm environment, location of his / her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event.	F0689		06/29/2026
E0039 SS = E	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E0039	Active Shooter tabletop education was performed on 6/17/2026 for all staff. After Incident Report was completed for the tabletop education. Anyone residing in the building at the time of an emergency have the potential to be impacted by Emergency Preparedness practices. Tabletop and Live drills were scheduled in maintenance reporting system (TELS) every 6 months to be completed. After Incident Report blank form was added to agenda for those occurrences to be completed post-drill. Health Care Administrator or designee will monitor and report to QA/QAPI until significant compliance is met. Health Care Administrator and Executive Director have additional calendar invites that are reoccurring outside of the TELS system to ensure drills are conducted as required.	06/29/2026

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E0039 SS = E	Continued from page 11 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E0039		06/29/2026

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E0039 SS = E	Continued from page 12 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an	E0039		06/29/2026

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E0039 SS = E	Continued from page 13 actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:	E0039		06/29/2026

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E0039 SS = E	Continued from page 14 (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E0039		06/29/2026

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E0039 SS = E	Continued from page 15 emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at	E0039		06/29/2026

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E0039 SS = E	Continued from page 16 least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency	E0039		06/29/2026

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E0039 SS = E	Continued from page 17 plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to conduct the required exercises to test their emergency preparedness (EP) plan, to include participation in a full-scale exercise, an individual facility-based functional exercise, a mock disaster drill, a tabletop exercise, or activation of their emergency plan. This had the potential to affect all 54 clients who resided in the facility as well as all staff who worked there. Findings include: A review of the facility's EP plan on 5/28/26, indicated an after action report (AAR) for a tabletop exercise conducted on 3/5/26, involving an evacuation drill. The EP plan included two staff sign-in sheets; one dated 3/3/26, and titled Tabletop Emergency Evacuation Drill Sheet. The other one dated 3/5/26, and titled Emergency Evacuation Drill. During interview on 5/28/26 at 10:29 a.m., administrator stated they completed a tabletop exercise on 3/3/26, to plan the evacuation exercise to be completed on 3/5/26. Administrator further stated understanding was that this fulfilled the	E0039		06/29/2026

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E0039 SS = E	Continued from page 18 requirement for two exercises per year. During follow up interview on 5/28/26 at 10:34 a.m., administrator stated agreed that the AAR represented only one tabletop evacuation drill and the facility failed to complete a second community wide, facility based, or actual event to satisfy the annual requirement. The facility EP Plan dated January 2025, indicated the EP training and testing program was used to determine effectiveness of the plan and to ensure staff can demonstrate knowledge of emergency procedures. The policy further indicated, “Testing exercises using emergency procedures will be conducted at least twice per year, including…A full scale exercise annually that is community based or when a community-based exercise is not accessible, a facility-based functional exercise….An additional annual exercise that may include…A second full-scale exercise that is community-based, or an individual, facility-based functional exercise…or a mock disaster drill…or tabletop exercise or workshop that is led by a facilitator that includes a group discussion, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.”	E0039		06/29/2026
F0919 SS = E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that a resident's call light was accessible and within reach while the resident was in the shower for 1 of 1 resident (R47) reviewed for call light accessibility. This failure had the potential to impact all residents who use the shower. Findings include: R47's quarterly Minimum Data Set (MDS), dated	F0919	Additional call light equipment installed in every resident bathroom. The additional call light will have the capability of reaching the shower/bathing area. R47 call light was installed in the bathroom on 6/19/2026. All residents with call lights installed by the toilet in their bathroom have the risk to be impacted by the same deficient practice. Additional call light will be installed in all resident bathrooms between the toilet and shower/bathing area to ensure resident call light is accessible from both the toilet and the shower/bathing area. Plant Operations Director or designee will report to QA/QAPI that installation is complete and compliance is met.	06/29/2026

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F0919 SS = E	Continued from page 19 2/24/26, identified that R47 was cognitively intact and had diagnoses of hemiplegia and hemiparesis (severe or complete paralysis of one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, heart failure, abnormalities of gait and mobility, and muscle weakness. The MDS further identified R47 had required maximal assistance with showering and toilet hygiene. R47's care plan, dated 9/5/25, identified that R47 had experienced an activity of daily living (ADL) self-care performance deficit. Interventions included assistance from one staff member with showering and toilet hygiene. Additionally, the ADL fall-risk interventions included ensuring the call light was within reach. During an observation and interview conducted on 5/27/26 at 12:14 p.m., R47 stated he had been seated in a shower chair while the water had been running. An unidentified nursing assistant (NA) had received a call on a walkie-talkie and had left R47's room. R47 stated that the bathroom call light box was located across the room next to the toilet. R47 was unable to reach the call light cord and had not been able to contact staff or call for help if necessary. Observation of R47's bathroom confirmed the placement of the call light box and the resident's inability to call for assistance while in the shower. During an interview conducted on 5/28/26 at 9:29 a.m., NA-B stated that residents used their call lights if they had experienced an issue. She stated that there had not been a call light available in the shower and that residents had not been left alone while showering. She further stated that it had never been acceptable to leave the room while a resident had been taking a shower. During an interview conducted on 5/28/26 at 9:48 a.m., licensed practical nurse (LPN)-C stated that staff had never been permitted to leave a resident unattended in the shower. She stated that residents had not been able to use the call light due to the location of the call light box next to the toilet. During an interview conducted on 5/28/26 at 11:52 a.m., the Director of Nursing (DON) stated that the expectation for staff had been to never leave a resident unattended while in the shower. The DON stated that, following installation of the new call light system, the call light box had been moved to the wall next to the toilet to provide easier access for residents while using the facilities. However, there	F0919		06/29/2026

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F0919 SS = E	Continued from page 20 had no longer been a call light box or cord accessible while a resident had been in the shower. The DON stated it was important for residents to have access to a call light to alert staff to any issue, emergency, or need. The policy titled “Call Light Accessibility and Timely Response,” dated January 2026, directed that the facility had been adequately equipped with a call light at each resident’s bedside, toilet, and shower/bathing facility to allow residents to call for assistance.	F0919		06/29/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F0550	R50’s Resident has a preference to call incontinence products “diapers”, and this was added to his care plan to reflect resident preference All staff education performed on “Promoting/Maintaining Resident Dignity”. Any resident that has a preference to call incontinence products by other terminology has the potential to be impacted by the deficient practice. Performed interviews with residents and updated care plans with residents’ preferences for terminology outside of approved terms like “brief”. Post education, staff will report to Social Services department resident preferences outside of approved terminology to ensure care plan is updated and preferences are communicated. Director of Nursing or designee will monitor and report to QA/QAPI until significant compliance is met. Director of Nursing or designee to complete audit to observe therapy staff and resident interactions once weekly for 1 month and every other week for 1 month to ensure incontinence is not discussed in public setting and resident preferences for terminology are used appropriately.	06/29/2026

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F0550 SS = D	Continued from page 21 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was preserved for 1 of 1 resident (R50) reviewed for dignity. Findings include: R50's quarterly Minimum Data Set (MDS) dated 5/13/26, identified intact cognition with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. His hearing was adequate without hearing aids and speech was clear. R50 required partial/moderate assist from staff for toileting hygiene. He was occasionally incontinent of urine and always continent bowel. No toileting program was in place. Diagnoses included arthritis, non-Alzheimer's dementia, and anxiety. R50's Care Area Assessment (CAA) dated 6/30/25, identified he was at risk for incontinence due to dementia, diabetes, congestive heart failure and diuretic medication use. R50's toileting care plan dated 11/11/25, identified he may self-toilet during the day and requires minimum assist of one in the evening and overnight. The care plan had not mentioned a preference to have his adult incontinence briefs called "diapers". R50's nursing progress notes dated 6/30/25 through 5/27/26, had not mentioned a preference to use the term "diaper" in conversation. During an observation at 5/28/26 at 8:30 a.m., R50 was in the public hallway walking with physical therapist (PT)-A. PT-A stated to R50, it looks like your "diaper" is sagging. A visitor walked by at the same time. R50 stated he thought so also. During an interview on 5/28/26 at 9:53 a.m., R50 stated he walked with PT earlier in the morning today. and that his brief was bunched up. R50 verified PT-B called his brief a diaper, and that it had not really bothered him. R50 agreed that he would rather have discussions in privacy rather than in the hallway, especially about his undergarments. During an interview on 5/28/26 at 9:55 a.m., nursing assistant (NA)-A stated he worked with R50 often. R50 would sometimes call his own undergarments "diapers" however staff would respond using the term "briefs" because "diaper" could be a demeaning term to say to an adult. During an interview on 5/28/26 at 10:00 a.m., PT-A stated he worked with R50 this morning and verified	F0550		06/29/2026

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F0550 SS = D	Continued from page 22 he called R50's brief a "diaper". PT-A stated R50 used the word "diaper" before so he thought it was okay. PT-B stated a more dignified term would be to call incontinence briefs a "pad". During an interview on 5/28/26 at 10:32 a.m., NA-C stated she worked with R50 routinely. R50 would sometimes call a brief a "diaper" however staff should respond using the term "briefs" and would not talk about a resident's incontinence products in a public area. During an interview on 5/28/26 at 10:55 a.m., the director of rehabilitation services (DRS) stated she would not expect staff to talk about an adult's incontinence products in a publica area and the term "diaper" could be undignified. The facility's Promoting/Maintaining Resident Dignity policy dated 10/2022, identified the facility would protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident’s quality of life by recognizing each resident’s individuality.	F0550		06/29/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure provider orders were transcribed accurately into the electronic medical record (EMR) for 2 of 2 residents (R25,R61) and failed to ensure verbal orders were received accurately for 1 of 1 resident (R15), for residents reviewed for order accuracy. Findings include: R25	F0684	Split: R25 has since discharged from the facility. During the annual survey, the facility added R61’s Speech-Language Pathologist (SLP) orders to the resident’s care plan, which updates the Nursing Assistant Registered (NAR) Kardex. The facility also attached the notes to the resident’s care profile so nurses can review the special eating instructions and ensure all staff are aware. R61 has since been upgraded to be able to eat independently without supervision by SLP. R15 order for Apixaban for “weight loss” was corrected on 5/28/26, during annual survey, to reflect appropriate diagnosis of Atrial Fibrillation. R15 has since discharged from the facility. Split: Audit conducted to review all current residents for PRN orders to ensure they have been accurately transcribed into PointClickCare (PCC).	06/29/2026

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F0684 SS = D	Continued from page 23 R25's admission Minimum Data Set, (MDS) dated 4/27/26, indicated R25 had intact cognition, required substantial to maximal assistance for toileting, and was frequently incontinent of bowel and bladder. R25's diagnoses included displaced intertrochanteric fracture (broken hip) of the left femur, muscle weakness, displaced fracture of shaft of fourth metacarpal (finger) bone of right hand, and diarrhea. R25's care plan dated 4/23/26, indicated R25 was incontinent with bowel and bladder and had an ADL (activities of daily living) deficit related to diagnoses including diarrhea. The care plan indicated R25 required substantial/maximal assistance of 1 staff with toileting tasks. R25's admission order dated 4/16/26, indicated, "loperamide 2 milligram (mg) capsule Commonly known as: IMODIUM Used for: Chronic diarrhea…Dose: 2-4 mg Take 1-2 capsules [2-4mg] by mouth 4 times daily as need for diarrhea." Additionally, "Continue taking all home meds." R25's pharmacist's recommendation to prescriber dated 4/27/26, identified loperamide was ordered with a dose range of "2-4mg QID [four times a day] PRN [as needed] and recommended "Clarification of Imodium Give 1 tablet PO [by mouth] PRN QID." R25's provider order dated 4/30/26, indicated, "Loperamide HCl Oral Tablet 2 MG…Give 1 tablet by mouth every 6 hours as needed for diarrhea." R25's May 2026, medication administration record (MAR) indicated R25 was given Imodium once on 5/7, 5/8, 5/12, and 5/25. The MAR indicated R25 was given Imodium twice on 5/23; once at 2:12 p.m., and once at 8:46 p.m. R25's progress notes (PN) dated 5/23/26 at 2:12 p.m., indicated Imodium was given for diarrhea. PN at 3:55 p.m. indicated the administration of Imodium was ineffective. PN at 5:35 p.m. indicated R25 was "having loose stool x 4 today." PN at 8:46 p.m. indicated R25 was given a dose of Imodium. PN at 10:37 p.m. indicated the administration of Imodium was effective. R25's provider visit note dated 5/18/26, identified in a review of systems (ROS) R25 had chronic diarrhea and required PRN Imodium. During interview on 5/26/26 at 12:32 p.m., R25 stated she suffered from bowel issues, had frequent diarrhea, and used Imodium regularly at home. R25 stated the staff here were "stingy" with Imodium and	F0684	Continued from page 23 Audit was conducted on all residents who are currently on SLP case load to review for specific SLP instructions. Care plans updated as needed to reflect SLP instructions. Facility reached out to Sterling Pharmacy representative to perform whole facility review of medication orders to ensure proper diagnoses. Residents who are found to not have appropriate diagnosis are at risk of the deficient practice. Split: Facility will transcribe medication orders involving "BID", "TID", "QID" PRN into PCC without time constraints unless otherwise specified by provider. Education to be given to the nursing team and providers on the updated process and for providers to include time constraints or dosing limitations, if desired. Admissions personnel to review orders when received and to notify Nurse Managers email group of any SLP Instructions, staff members who complete admissions were educated on the updated process. Director of Nursing or designee will monitor and report to QA/QAPI until significant compliance is met. Education given to all nurses on ensuring proper diagnoses for medications. Split Audits to be conducted 1 time weekly for 5 residents for 1 month then every other week for 2 months to review residents with PRN medications to ensure proper transcription. Director of Nursing or designee will monitor and report to QA/QAPI until significant compliance is met. Audits to be conducted on all new admissions for 2 months for SLP Instructions/Orders. Director of Nursing or designee will monitor and report to QA/QAPI until significant compliance is met.	06/29/2026

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F0684 SS = D	Continued from page 24 would only give it to her after two to three loose stool. R25 further stated the staff would make her wait after an initial dose was ineffective and cause her to experience several more episodes of loose stool. R25 stated at home she took the medication per the instructions on the package which instructed to take two tablets after the first episode of diarrhea and then one tablet if ineffective with a maximum of four doses a day. During interview on 5/27/26 at 10:10 a.m., nurse practitioner (NP)-A stated R25 was admitted with an order for a range dose for Imodium of 2-4 mg. NP-A stated dose ranges were not allowed in long term care facilities. NP-A further stated she wrote a new order for clarification for R25 to have one 2mg tablet as needed for diarrhea and that she could have that up to four times a day. During interview on 5/27/26 at 1:05 p.m., licensed practical nurse (LPN)-A stated if medication was ordered every six hours as needed, the resident would have to wait five to six hours in between doses. LPN-A stated if a medication was ordered four times a day. LPN-A stated that in the case a PRN medication was administered and was ineffective, a second dose could be given without waiting a specific amount of time. During follow up interview on 5/27/26 at 2:20 p.m., NP-A stated the Imodium was ordered as QID and should have been entered into R25's MAR accurately so that if the first dose was ineffective, a second dose could be given right away and not have to wait six hours. During interview on 5/27/26 at 2:31 p.m., registered nurse (RN)-A stated would expect orders would be entered as written. If the order was for QID should not have been entered as every six hours. During interview on 5/28/26 at 11:09 a.m., health unit coordinator (HUC) stated was initially taught to enter orders with a specific timeframe and was not aware that four times a day could be used. R61 R61's admission MDS was in progress. R61's hospital Discharge Summary dated 5/23/26, identified on 5/20/26, R61 had an episode of shortness of breath, oxygen was required, and a chest x-ray was obtained to see if he aspirated. R61 would discharge to a transitional care unit (TCU) and discharge orders for swallowing instructions	F0684	Continued from page 24 Audits to be conducted 1 time weekly for 5 residents for 1 month then every other week for 2 months to review resident medication lists to ensure proper medication diagnoses. Director of Nursing or designee will monitor and report to QA/QAPI until significant compliance is met.	06/29/2026

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F0684 SS = D	Continued from page 25 identified full supervision and assistance with all PO (by mouth). R61's hospital progress notes dated 5/22/26, identified the chest x-ray for questionable aspiration was negative for any infiltrate. R61's facility nursing Admission Assessment dated 5/23/26, identified a diagnosis of unstable fracture of the first cervical vertebra. R51 was alert and oriented to person, place, time and situation and always required an Aspen collar (rigid orthotic device worn around the neck to immobilize the cervical spine) on due to cervical fracture. No mealtime supervision was identified. R61's facility diet order dated 5/23/26, identified full supervision and assistance with all PO. R61's facility activities of daily living (ADL) care plan dated 5/23/26, identified set up and clean up assistance was required for eating. No mealtime supervision was identified. R61's Kardex (nursing assistant care guide with interventions pulled from the care plan) printed 5/26/26, identified set up and clean up assistance was required for eating. No mealtime supervision was identified. R61's facility diet order had not been pulled into the care plan or the Kardex for staff to be aware of the order. R61's facility speech language pathologist (SLP) recommendations progress note dated 5/26/26 at 9:53 a.m., identified "resident must be supervised during oral intake due to aspiration risk." R61's Point of Care (POC) charting dated 5/23/26 through 5/26/26, identified no mealtime supervision was provided. During an observation on 5/26/26 at 12:06 p.m., R61's was not in his room, and his lunch was on the tray table in his room. At 12:07 p.m., physical therapist (PT)-B brought R61 into his room, moved the bedside table in front of him and set up his meal. PT-B placed an instruction sheet in front of R61 which identified: Sit upright while eating and drinking Eat at a slow rate	F0684		06/29/2026

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F0684 SS = D	Continued from page 26 Take one small bite at a time and chew well Wash down every bite with a small drink Swallow multiple times for each bite drink Brush teeth after meals. No mealtime supervision was identified on the instruction sheet. During a continuous observation on 5/26/26 from 12:11 p.m. through 1:09 p.m., R61 ate his lunch in his room, and no staff had supervised his intake. During an interview on 5/27/26 at 10:57 a.m., RN-E stated she entered R61's admission orders. The root cause of staff not being aware of the mealtime supervision order from the hospital was because the way the order was entered, it did not pull through to the Kardex or care plan so staff could be aware. RN-E stated she would expect orders to be entered in a way that is visible to the staff caring for the residents. RN-E stated there could be a risk of choking because R61's order was not entered correctly. During an interview on 5/27/26 at 10:31 a.m., RN-A stated she was the manager and would review admission orders, history and physicals, and update the care plan within 72 hours and ensure accuracy. RN-A verified R61's hospital orders for mealtime supervision due to risk of aspiration. RN-A verified R61's facility admission assessment lacked indication for mealtime supervision, therefore that intervention had not pulled into the care plan or Kardex for staff to be aware. RN-A verified the order should have been entered in the computer in a way that the staff caring for the residents were aware of the mealtime supervision, the way the order was entered into the medical record was not initially correct. During an interview on 5/27/26 at 11:57 a.m., LPN-B stated she helped enter R61's admission orders. For residents that require mealtime supervision, that should pull through on the toe treatment administration record (TAR), care plan and Kardex. LPN-B was not aware of any issues with the order transcription yet. LPN-B stated she was not able to	F0684		06/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245632	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Therese Of Woodbury Llc	7555 BAILEY ROAD , WOODBURY, Minnesota, 55129

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F0684 SS = D	Continued from page 27 observe R61 at mealtimes when he was admitted, and that he ate his evening meal in his room without supervision. During an interview on 5/27/26 at 2:19 p.m., R61's nurse practitioner (NP)-A stated he was at moderate to high risk of aspiration since he had an order for full supervision at mealtimes. NP-A stated when she did her admission visit with R61 on 5/26/26, he had no respiratory concerns, and she noted he was eating 50-100% of his meals. NP-A stated his choking risk was related more so to the Aspen collar needing to be on at mealtimes. He has been eating 50-100%. NP-A stated she would expect admission orders to be entered accurately. R15 R15's admission MDS dated 4/6/26, indicated moderately impaired cognition, a diagnosis of atrial fibrillation (A-fib, irregular heartbeat), and received an anticoagulant (blood thinner) medication on a routine basis. R15's after visit summary (AVS) dated 3/24/26, indicated R15 was to start taking apixaban (anticoagulant medication) 5 milligram (mg) tablet for diagnosis of A-fib. Take 1 tablet by mouth 2 times daily. R15's physician's order (taken verbally by registered nurse (RN)-F and written in the physician's order book (white) at the nurse's station) dated 4/30/26, indicated apixaban oral tablet 2.5 mg by mouth two times a day with a diagnosis of weight loss. R15's physician's orders in the electronic medical record (EMR) indicated on: -4/30/25, apixaban oral tablet 2.5 mg. Give 2.5 mg by mouth two times a day for weight loss. -3/28/26, monitor R15's weight. If her weight falls below 60 kilograms (kg) or 132 pounds (lbs.), reduce apixaban to 2.5 mg twice a day, every shift (day) and notify the provider. R15's care plan dated 3/28/26, indicated R15 was receiving anticoagulant therapy related to A-fib with the following interventions: -staff will monitor for signs/symptoms of thromboembolism. Report if evident: pain or tenderness and swelling of arm/leg; increased warmth, edema and/or redness of affected extremity,	F0684		06/29/2026

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F0684 SS = D	Continued from page 28 unexplained shortness of breath; chest pain, or coughing, -hemoptysis (spitting up blood) -feeling of anxiety or dread. During interview on 5/27/26 at approximately 11:00 a.m., RN-D verified the original order for apixaban was prescribed on 3/24/26, for the diagnosis of A-fib and on 4/30/26, there was a new verbal order (from NP-A) to decrease the dose to 2.5 mg and that's when the diagnosis changed to weight loss. During interview on 5/27/26 at 12:58 p.m., RN-A stated when a resident was admitted or returned with new orders, the admissions coordinator would usually enter them and then a nurse was required to verify those orders. If there was a discrepancy, or clarification was needed, the NP would let the prescribing provider know and then the NP would make the changes to the order. RN-A stated apixaban was not used to treat weight loss and someone with nursing knowledge should know that would not be an appropriate diagnosis. During interview on 5/28/26 at 8:50 a.m., NP-A stated R15 was prescribed apixaban for A-fib on 3/24/26, and then she reduced the dose on 4/30/26, due to her having weight loss. NP-A further stated, she wasn't sure if she had given the order verbally or if she had written it in the book herself and would need to check to see if it was her handwriting, but the indication shouldn't have changed stating "Everyone knows you don't prescribe apixaban for weight loss." During interview on 5/28/26 at 11:00 a.m., RN-F stated the process for receiving verbal orders was to write the order in the white book in the nurse's station and then read the order back to the physician for clarification. Then the nurse should then enter the order into the EMR, and then it had to be verified by another nurse. During interview on 5/28/26 at 11:22 a.m., RN-G stated the process for receiving verbal orders from the physician was to write them in the book (white book in the nursing station). If the order was from the on-call physician, the nurses were also required to indicate who the resident's primary physician was, and the RN's name who was transcribing the order. If the order was something that needed to be addressed immediately, the nurse would enter the order and have another nurse verify it. If it was an order that didn't need to be addressed right away,	F0684		06/29/2026

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F0684 SS = D	Continued from page 29 the health unit coordinator (HUC) would enter the order and then a nurse was required to verify it. RN-G further stated all nurses who received verbal orders from the physician were required to read the order back to them for clarification. During an interview on 5/27/26 at 1:37 p.m., the director of nursing (DON) stated two nurses would check admission orders for accuracy. Mealtime supervision orders should be entered in a way they pull through to the care plan and Kardex so the staff caring for the residents would be aware. After the SLP noticed the order transcription error, she updated nursing and the order was corrected. The DON stated the way the order was initially entered, not all staff could see it clearly. The DON stated he expected all resident orders to be entered correctly and to reach the appropriate staff caring for the residents. Facility policy Medication Orders dated January 2026, indicated medication orders must have several elements including but not limited to, dose-strength, time or frequency of administration, diagnosis or indication for use, and condition for which being administered if PRN. The policy further indicated orders must be entered into the electronic health record orders must be transcribed on the MAR or treatment record and ensure the order was on the electronic MAR.	F0684		06/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245632	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - ST THERESE...** B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on May 26, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Therese of Woodbury LLC, 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		06/24/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245632	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - ST THERESE...** B. WING	(X3) DATE SURVEY COMPLETED **05/26/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: ST THERESE OF WOODBURY is a 2-story building with a full basement. The original building was built in 2016 and was determined to be of Type II (111) construction. The facility has 2-hour fire separation between the nursing home and the assisted living portions of the structure The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		06/24/2026

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K0311 SS = F Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to seal the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition sections 8.6 and 19.3.1.1 . This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 5/26/2026, at 11:45 AM, observations and staff interview revealed that the soiled linen chute in room Soiled Holding Room in the basement was not properly sealed at the deck to prevent smoke or fire from transferring to other floors. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0311	Soiled linen chute has been sealed to ensure proper smoke/fire barrier. There are no other linen chutes in the facility to inspect for other potential deficiency. There are no other linen chutes in the facility to inspect for other potential deficiency and the Soiled linen chute has been sealed to ensure proper smoke/fire barrier. Plant Operations Director or designee will report to QA/QAPI that solid linen chute has been sealed	06/29/2026
K0324 SS = F 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)	K0324	Stainless steel strips installed to reduce gaps in kitchen hood filters to meet regulations. No other areas in the facility identified. No other areas in the facility identified. Stainless steel strips installed to reduce gaps in kitchen hood filters to meet regulations. With stainless steel strips installed kitchen hood	06/29/2026

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K0324 SS = F Bldg. 01	Continued from page 3 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 observation and staff interview, the facility failed to protect the cooking ventilation system in accordance with the NFPA 96, 6.2.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 05/26/2026, between 12:10 PM, observations and staff interview revealed that the kitchen hood filters were not properly sealed leaving a 1/2" gap between the filters. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0324	Continued from page 3 filter gaps, the deficiency has been corrected. Plant Operations Director or designee will report to QA/QAPI compliance is met.	06/29/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day	K0918	Generator batteries were tested for specific gravity or conductance. There are no other emergency generator batteries to be tested in the facility. Testing of the generator batteries will be completed weekly by the Plant Operations Director or designee. Plant Operations Director or designee will report to QA/QAPI monthly for 3 months to ensure compliance is met.	06/29/2026

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K0918 SS = F Bldg. 01	Continued from page 4 intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 5/26/2026, at 11:30 AM, it was revealed by a review of available documentation, the facility was not testing the batteries for the Emergency Generators for specific gravity or conductance. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918		06/29/2026
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or	K0923	Vinyl flooring was removed to reflect non-combustible, solid concrete flooring. There are no other oxygen rooms in the facility to inspect for other potential deficiency. No other areas are affected. Plant Operations Director or designee will report to QA/QAPI that the vinyl flooring has been removed.	06/29/2026

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K0923 SS = F Bldg. 01	Continued from page 5 within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to construct a storage space that is of non-combustible materials in accordance with NFPA 99, 11.3.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 05/26/2026, between 12:40 PM, observations and staff interview revealed that the flooring within the Liquid Oxygen Storage and Transfilling Room is vinyl tile. NFPA 99 requires that the flooring in Liquid Oxygen Storage and Transfilling rooms be constructed of non-combustible materials. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0923		06/29/2026

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K0511 SS = E Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to secure electrical boxes in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.1, NFPA 70 (2011 edition), National Electrical Code, section 300.19(C)(2), 314.25, 314.28(C) This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 5/26/2026 at 12:10 PM, it was revealed by observation that the electric panels at the entrance to the Kitchen were not properly secured and were being blocked by carts. These panels are accessible to residents of this facility. An interview with the Maintenance Director and the Administrator in Training verified this deficient finding at the time of discovery.	K0511	The electrical panel in the kitchen has been locked. All other electrical panels audited by Plant Operations Director or designee and found to be secured. Audits to be completed to check all electrical panels 1 time monthly for 3 months. Plant Operations Director or designee will monitor and report to QA/QAPI that compliance is met.	06/29/2026