DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 23, 2026

Administrator
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY
3815 WEST BROADWAY AVENUE
ROBBINSDALE, MN 55422

RE: CCN: 245279
Cycle Start Date: May 14, 2026

Dear Administrator:

On June 1, 2026, we informed you that we may impose enforcement remedies.

On June 4, 2026, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby 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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 14, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 14, 2026. They will also notify

the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 14, 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 August 14, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 14, 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)

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

submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 14, 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 Steven Delich, Program Representative at (312) 886-5216. 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,

Kamala Fiske-Downing

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

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3815 WEST BROADWAY AVENUE
ROBBINSDALE, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 231A73-H1

Dear Administrator:

The above facility survey was completed on June 4, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING	**06/02/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on June 2, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Specialty Care Community, 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		07/10/2026

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

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

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K0000 Bldg. 02	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: Good Samaritan Society - Specialty Care Community is a 3-story building with a basement that was built in 2012 and determined to be Type II (111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with complete smoke detection that is monitored for automatic fire department notification. The facility has a capacity of 96 beds and had a census of 89 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		07/10/2026
K0918 SS = F Bldg. 02	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K0918	K0918 (SS=F): Electrical Systems – Annual Fuel Testing Survey cited missing documentation of annual	07/10/2026

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K0918 SS = F Bldg. 02	Continued from page 2 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain 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 8.3.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 6/2/2026, at 11:15 AM, it was revealed by a review of available documentation, the facility did not have documentation on the annual fuel testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918	Continued from page 2 generator fuel testing. Annual fuel testing for the emergency generator was completed on 6/8/2026. Documentation of testing was obtained and placed in the facility maintenance compliance binder. All residents residing in the facility had the potential to be affected by this deficient practice due to reliance on the Emergency Power Supply System during a power outage. No residents were negatively impacted by this deficient practice. To ensure the deficient practice will not recur, education was provided to the Maintenance Director and designee on 6/25/2026 regarding required EPSS testing and documentation, including annual fuel quality testing per NFPA requirements. A preventive maintenance tracking system was updated to include annual fuel testing due dates and documentation requirements. To ensure compliance is maintained, the Maintenance Director or designee will audit emergency generator compliance documentation weekly x 4 and monthly x 3 to ensure all required testing is completed and documented timely. Audit results will be reviewed through QAPI for further recommendations. Compliance date: 7/10/2026	07/10/2026

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K0353 SS = E Bldg. 02	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 25 (2011 edition) (5.2.2.2). This deficient finding could have a moderate impact on the residents within the facility. Findings include: On 6/2/2026, at 12:15 PM, it was revealed by observation that at the entrance to the Arrowhead Unit, there were wires in contact with the sprinkler system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	K0353 (SS=E): Sprinkler System – Wires Touching Sprinkler Pipe Survey cited wires in contact with sprinkler system at Arrowhead Unit entrance. The wires in contact with the sprinkler system at the entrance to Arrowhead Unit will be removed/resecured to maintain required clearance by 7/10/2026. All residents residing in the facility had the potential to be affected by this deficient practice. A facility-wide inspection of sprinkler piping and surrounding areas will be completed by 7/10/2026 to identify any additional obstructions or contact points. No additional concerns were identified / Additional concerns were corrected immediately. To ensure the deficient practice will not recur, education was provided to maintenance staff on 6/25/2026 regarding maintaining required clearances around sprinkler components and identifying environmental hazards that could interfere with fire suppression systems. To ensure compliance is maintained, the Maintenance Director or designee will conduct environmental audits of sprinkler system clearance weekly x 4 and monthly x 3. Findings will be reported to QAPI for follow-up as needed. Compliance date: 7/10/2026	07/10/2026
K0362 SS = E Bldg. 02	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING	K0362	K0362 (SS=E): Corridor Walls / Firewall Penetrations Survey cited two firewall penetrations (Boundary and Bluff Country units). The two identified firewall penetrations at Boundary Unit and Bluff Country Unit were sealed with	07/10/2026

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K0362 SS = E Bldg. 02	Continued from page 4 Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas in accordance with the Life Safety Code NFPA 101 - 2012 edition 19.3.6.2. This deficient finding could have a moderate impact on the residents within the facility. Findings Include: On 6/2/2026, at11:45 AM, observations and staff interview revealed that there were 2 firewall penetrations, 1 at the entrance to the Boundry Unit and 1 at the Bluff Country Unit. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0362	Continued from page 4 approved fire-rated materials on 6/2/2026. All residents residing in the facility had the potential to be affected by this deficient practice. A facility-wide inspection of fire-rated walls and penetrations will be completed by 7/10/2026 to identify additional penetrations. Any identified penetrations were repaired immediately. To ensure the deficient practice will not recur, education was provided to maintenance staff on 6/25/2026 regarding identification of wall penetrations and maintaining fire barrier integrity. To ensure compliance is maintained, the Maintenance Director or designee will complete fire barrier audits weekly x 4 and monthly x 3. Results will be reviewed in QAPI for further recommendations. Compliance date: 7/10/2026	07/10/2026
K0293 SS = D Bldg. 02	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K0293	K0293 (SS=D): Exit Signage Survey cited missing “Not an Exit” sign on Arrowhead Patio access door. A “Not an Exit” sign will be installed on the Arrowhead Patio access door by 7/10/2026 . All residents residing in the facility had the potential to be affected by this deficient practice. A facility-wide audit of exit and directional signage	07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - MAIN BLDG** B. WING	(X3) DATE SURVEY COMPLETED **06/02/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422**

(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
K0293 SS = D Bldg. 02	Continued from page 5 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed maintain the egress requirements in accordance with NFPA 101, 7.10.8.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 6/2/2026, at 11.30 AM, observations and staff interview revealed that the access door to the Arrowhead Patio did not have the required "Not an Exit" sign. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0293	Continued from page 5 was completed on DATE to identify missing or noncompliant signage. Any identified concerns were corrected immediately. To ensure the deficient practice will not recur, education was provided to maintenance staff on 6/25/2026 regarding required exit and directional signage and egress requirements per Life Safety Code. To ensure compliance is maintained, the Maintenance Director or designee will complete exit signage audits weekly x 4 and monthly x 3. Results will be reviewed through QAPI for follow-up as needed. Compliance date: 7/10/2026	07/10/2026
K0324 SS = D Bldg. 02	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K0324	K0324 (SS=D): Cooking Facilities – Missing 120-Minute Stove Timer Survey cited missing 120-minute timer on therapy/rehab stove. A compliant 120-minute timer will be installed on the stove in the Therapy and Rehab space by 7/10/2026. All residents residing in the facility had the potential to be affected by this deficient practice. A facility-wide audit of all resident-accessible cooking appliances will be completed on 7/10/2026 to ensure required safety devices were installed and functioning properly. Any identified concerns were corrected immediately. To ensure the deficient practice will not recur, education was provided to maintenance staff and department leaders on 6/25/2026 regarding cooking equipment safety requirements, including timer requirements for resident-accessible cooking appliances. To ensure compliance is maintained, the Maintenance Director or designee will audit cooking equipment safety weekly x 4 and monthly x 3. Audit findings will be brought to QAPI for further	07/10/2026

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K0324 SS = D Bldg. 02	Continued from page 6 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed install the required 120 minute timer accordance with NFPA 101, 19.3.2.5.3 (9). This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 6/2/2026, at 12:15 PM, observations and staff interview revealed that the stove within the Therapy and Rehab space did not have the required 120 minute time installed to safeguard the stove. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0324	Continued from page 6 recommendations. Compliance date: 7/10/2026	07/10/2026

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F0000	INITIAL COMMENTS On 5/13/26 and 5/14/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52791621C (2992414). As a result of the investigation deficiencies were cited at F550, F656, and 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 that substantial compliance with the regulations has been attained.	F0000		06/19/2026
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	F0550	R1 was discharged from facility at time of survey. All residents have the potential to be affected by this deficient practice. Facility staff interviewed residents and staff who provide care on this unit to ensure that care is being provided with dignity and respect. Anyone found to have been impacted received appropriate corrective actions using a person-centered approach. To ensure deficient practice will not recur, education on policies: Resident Dignity will be provided to all staff by the Director of Nursing Services or designee via in-person training by 6/19/2026 or prior to next working shift.	06/19/2026

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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F0550 SS = D	Continued from page 1 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. §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 interview, observation, and document review, the facility failed to promote dignity while providing care for 1 of 3 residents (R1) reviewed who required assistance with activities of daily living. Findings include: R1's admission Minimum Data Set (MDS) dated 3/26/26, indicated R1 admitted to the facility on 3/20/26, was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included dementia. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she had a video of staff yelling at R1 when R1 asked for help. The FM-A stated R1 reported being upset after staff yelled at her. The FM-A did not understand why staff would yell at a resident with the diagnosis of dementia. The FM-A stated it was upsetting to see the video and further stated she wanted R1 cared for by people who wanted to help R1. The staff in the video did not seem like they wanted to help.	F0550	Continued from page 1 To ensure compliance is maintained, random audits of care interactions focused on resident dignity and rights will be completed by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to ensure concerns are addressed timely. Results will be brought to the QAPI committee for further recommendations. Compliance date 6/19/2026.	06/19/2026

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F0550 SS = D	Continued from page 2 During an interview on 5/13/26 at 4:04 p.m., the nursing assistant (NA)-C stated staff should not call residents grandma or momma because it was not professional, and it was not allowed at the facility. Staff should instead call residents by their preferred name and should treat residents kindly. During an interview on 5/13/26 at 4:17 p.m., the registered nurse (RN)-B stated staff were supposed to be respectful and call resident's by their preferred name, not momma or grandma. During an observation with the administrator and the director of nursing (DON) on 5/14/26 at 11:00 a.m., review of a video from the camera in R1's room dated 4/3/26 at 7:54 p.m., revealed two staff talking to R1. The DON and administrator identified the staff in the video as NA-E and NA-E. NA-E told R1 she was asking for help for no reason, stated R1 was "cutting up" and it was the last time staff would be in the room. NA-E then addressed R1, "grandma." The DON stated staff should treat residents with respect. Also during the observation and review of a video from the camera in R1's room dated 4/3/26 at 8:14 p.m., revealed two staff, the NA-A and the NA-B, transferred R1 with a Stand Aid (device used to assist resident from sitting to standing position and from standing to sitting position). The DON and administrator acknowledged it was NA-A in the video and the NA-A who was standing in front of R1 during the transfer who encouraged R1 to sit. When R1 sat the NA-A stated, "There you go momma." During an interview on 5/14/26 at 1:46 p.m., the NA-B stated she had not worked with R1, even though she was identified by the administrator and DON in the video dated 4/3/26 at 8:14 p.m. During an interview on 5/14/26 at 1:48 p.m., the DON stated staff was expected to be respectful towards residents, the preferred name could be added to the care plan. Staff were not allowed to call residents grandma or momma because that was not respectful. The Resident Dignity policy dated 12/18/25 indicated staff would care for residents in a manner that maintained or enhanced each resident's dignity and respect and treat residents with respect and address each resident by their preferred name.	F0550		06/19/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F0656	R1 was discharged from facility at time of survey. All residents have the potential to be affected by this	06/19/2026

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F0656 SS = D	Continued from page 3 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and document review the facility failed to implement care plan	F0656	Continued from page 3 deficient practice. To identify residents at potential risk, DNS or designee will observe residents requiring transfers using mechanical lift or stand aids according to care plans and ensure staff conduct transfers as care plan directs at time of observation. To ensure deficient practice will not recur, education on policies: Care Plans will be provided to all staff by the Director of Nursing Services or designee via in-person training by 6/19/2026 or prior to next working shift. To ensure compliance is maintained, the DNS/designee will complete random audits of resident transfer and cares weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations. Compliance date 6/19/2026.	06/19/2026

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F0656 SS = D	Continued from page 4 interventions for 1 of 3 residents (R1) when staff transferred R1 with pivot transfers (technique for moving a resident from one position to another. While standing, resident moves their feet to turn toward the new surface) instead of with the Stand Aid (non-motorized device to assist a person to a standing position), as indicated in the care plan. Findings include: R1's admission Minimum Data Set (MDS) dated 3/26/26 indicated R1 admitted to the facility on 3/20/26, was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included fractures, dementia and multiple traumas. R1's care plan dated 3/23/26 indicated R1 required assistance of one staff for toileting and transferred with a Stand Aid. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she was concerned about the way staff transferred R1. R1 was transferred by two people moving R1 instead of the machine [stand aid] staff were supposed to use. FM-A stated she had videos of R1's transfer from the toilet to the wheelchair, and from the wheelchair to the bed, indicating staff did not use the stand aid for transfers. During an interview on 5/13/26 at 3:56 p.m., the nursing assistant (NA)-D stated she did not recall how R1 was supposed to transfer, but staff would refer to the therapy book on the counter of the nurses' station to know how each resident was supposed to transfer. During an interview on 5/13/26 at 4:04 p.m., NA-C stated she was supposed to use the Stand Aid to transfer R1. The NA-C stated she always used the Stand Aid with R1 and did not transfer R1 without it because R1 could fall using a pivot transfer. During an interview on 5/13/26 at 4:44 p.m., the administrator stated R1's care plan indicated R1 required use of the stand aid and staff assistance for transfers. During an interview on 5/13/26 at 4:49 p.m., the registered nurse (RN)-A stated she did not remember R1. The RN-A stated a resident's care plan directed staff in how to transfer a resident safely and it was unsafe to transfer a resident with a pivot transfer instead of a Stand Aid if the therapy department directed staff to use a Stand Aid.	F0656		06/19/2026

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F0656 SS = D	Continued from page 5 During an interview on 5/14/26 at 10:13 a.m., the licensed practical nurse (LPN)-A stated when a resident's care plan indicated transfer with a Stand Aid, staff should transfer with a Stand Aid. R1 required the Stand Aid because she could not bear weight on both legs. During an observation with the physical therapy assistant (PTA)-A on 5/14/26 at 10:40 a.m., upon review of the video footage from the camera in R1's room, dated 4/4/26 at 8:17 p.m., revealed two staff pivot transferred R1 from the toilet to her wheelchair. The two staff did not use the Stand Aid. The PTA-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 10:40 a.m., the PTA-A stated R1 was supposed to be transferred with a Stand Aid, and not with a two-person pivot transfer. The transfers on the video footage was not completed according to R1's care plan. Further, the PTA-A stated the therapy department kept a book at the nurses' station which gave direction how each resident was supposed to be transferred. The PTA-A stated R1 was supposed to transfer with the Stand Aid. During an observation with the administrator and clinical director (CD)-A on 5/14/26 at 11:00 a.m., upon review of the video dated 4/4/26 at 8:17 p.m., revealed two staff pivot-transferred R1 from the toilet to her wheelchair instead of using a Stand Aid. The administrator and CD-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 11:00 a.m., the CD-A stated he did not see a Stand Aid in the videos. If the care plan indicated staff were supposed to use a Stand Aid, they should have used a Stand Aid for safety to ensure the resident did not fall. During an interview on 5/14/26 at 1:07 p.m., the director of nursing (DON) and administrator identified the staff from the two videos who transferred R1 from the toilet to the wheelchair and the wheelchair to the bed without a Stand Aid as NA-C and NA-D. During an interview on 5/14/26 at 1:34 p.m., the NA-A acknowledged she worked on 4/4/26 and	F0656		06/19/2026

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F0656 SS = D	Continued from page 6 assisted another staff to transfer R1 with a gait belt from the toilet to the wheelchair. The NA-A was aware R1's care plan indicated use the Stand Aid. The NA-A stated the Stand Aid was not used because R1 wanted to transfer with the gait belt instead. The NA-A stated she preferred to transfer residents with a pivot transfer and gait belt instead of using a Stand Aid, but sometimes R1 was able to stand and sometimes could not. R1 was not always able to remember to stand because R1 had dementia. The NA-A stated if the resident did not want to follow the care plan and use the Stand Aid, the NAs could talk to the nurse and use a two-person assist for transfers instead of following the care plan. During an interview on 5/14/26 at 1:49 p.m., NA-B stated she did not remember working with R1. To know how a resident was supposed to transfer, staff referred to the therapy book at the nurses' station or asked another staff who knew the resident. During an interview on 5/14/26 at 1:48 p.m., the DON stated R1 was supposed to transfer with a Stand Aid and one staff per R1's care plan. Therapy staff determined the residents' ability to transfer and put each resident's transfer status in the therapy book at the nurses' station. If a resident did not choose to follow the care plan the NA would ask a nurse for help to educate the resident about the risks and benefits of not following the care plan for safe transfers. When a resident has dementia, staff should attempt to perform the transfer according to the care plan for safety to prevent falls. The Care Plan for Therapy and Rehab policy dated 12/1/25 indicated the care plan used to provide guidance to the interdisciplinary team. The Safe Resident Handling Program (SRHP) policy dated 7/7/25 indicated the SRHP provided interventions to provide caregivers the guidance for type of equipment, type of size of sling, and number of people to safely complete mobility tasks. The Stand Aid was used for residents who demonstrated leg strength for weight-bearing and were able to hold their torso in an upright position and pull themselves to a standing position. The responsibility of the staff was to eliminate manual lifting whenever possible by utilizing equipment and safe lifting practices.	F0656		06/19/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F0689	R1 was discharged from facility at time of survey. All residents that transfer with assistance have the	06/19/2026

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F0689 SS = D	Continued from page 7 §483.25(d) Accidents. 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 interviews, observations, and document review the facility failed to ensure safe transfers for 1 of 3 residents (R1) who was lifted off the floor following a fall by two staff without using a Hoyer lift (mechanical lift used to transfer residents from one surface to another). In addition, two staff assisted R1 to stand from a wheelchair with a Stand Aid (non-motorized lift used to assist residents from a seated position to a standing position) without a gait belt. Findings include: R1's admission Minimum Data Set (MDS) dated 3/26/26, indicated R1 admitted to the facility on 3/20/26, was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included fractures and dementia. R1's care plan dated 3/23/26, indicated R1 required one staff to assist with toileting and transfers with a Stand Aid. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she was concerned staff were transferring R1 by two people moving R1 instead of the machine (Stand Aid) staff were supposed to use. The FM-A further stated she was concerned about how staff transferred R1 when they did use the Stand Aid because they did not have the required belt around R1 and pulled on R1's arms to get her out of the chair. FM-A stated she had videos of R1's transfers from the camera in R1's room. During an interview on 5/13/26 at 3:56 p.m., the nursing assistant (NA)-D stated she did not recall how R1 was supposed to transfer, but staff would refer to the therapy book on the counter of the nurses' station to know how each resident was supposed to transfer. The NA-D stated when a resident fell and an NA found the resident on the floor, the NA was supposed to get a nurse to assess	F0689	Continued from page 7 potential to be affected by this deficient practice. DNS or designee will observe residents requiring transfers using stand aid reviewing for gait belts use. DNS reviewed all residents who have had a fall within the last 14 days to ensure Hoyer lift was utilized when lifting resident off of the floor on 6/3/2026. If deficient practice found at observations, immediate correction was taken as appropriate. The policy: Safe Resident Handling Program (SRHP) was reviewed and determined appropriate. To ensure deficient practice will not recur, education on policies: Safe Resident Handling Program (SRHP) will be provided to all staff by the Director of Nursing Services or designee via in-person training by 6/19/2026 or prior to next working shift. This training includes how to assist residents from the floor following a fall. To ensure compliance is maintained, the DNS/designee will complete random audits of resident transfer and cares weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations. Compliance date 6/19/2026.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422

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F0689 SS = D	Continued from page 8 the resident. If the resident was not injured the NA and the nurse would use a Hoyer lift to assist the resident from the floor. Staff used a Hoyer lift to prevent further injury and always used a Hoyer without exception. The NA-D did not recall helping R1. During an interview on 5/13/26 at 4:04 p.m., NA-C stated staff always used a Hoyer lift to assist residents off the floor after a fall. Staff could not lift the residents from the floor without a Hoyer lift, and a nurse had to be present. The NA-C stated she was supposed to use a Stand Aid to transfer R1. During an interview on 5/13/26 at 4:17 p.m., registered nurse (RN)-B stated after a resident fell, the nurses were supposed to assess the resident, take vital signs, perform neurological checks, and inform the resident's medical provider of the fall and assessment results. When a resident fell, the staff would use a Hoyer lift to get the resident off the floor, and staff were not allowed to just pick the resident up without the Hoyer lift. When staff utilized a Stand Aid for transfers, two staff were required, staff were supposed to use a gait belt around the resident for support as needed. Staff should not pull on the resident's hands or arms because it could injure the resident's shoulders. During a follow-up interview on 5/13/26 at 4:20 p.m., the NA-C stated she always used a Stand Aid with R1 and did not transfer R1 without it because R1 could fall. During an observation on 5/13/26 at 4:44 p.m. with the administrator and director of nursing (DON), of a video from the camera in R1's room, dated 3/30/26 at 8:17 p.m., two staff lifted R1 from the floor using R1’s arms, without a gait belt or Hoyer lift. During an interview on 5/13/26 at 4:44 p.m. the administrator identified the two staff who lifted R1 off the floor without a Hoyer lift as RN-A and NA-D. The DON was present during the interview and the administrator stated using a gait belt to get a resident off the floor would be best practice. The DON stated the facility recommended staff use a Hoyer to get residents off the floor. The administrator acknowledged she was not sure what the facility policy indicated for transfers off the floor, but would look. During an interview on 5/13/26 at 4:49 p.m., the registered nurse (RN)-A stated she did not remember R1. The RN-A stated when a resident was found on the floor, the nurse was expected to perform an	F0689		06/19/2026

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F0689 SS = D	Continued from page 9 assessment, and then if the resident was not injured, staff would assist the resident off the floor with a Hoyer lift for the safety of the resident, and to not cause injury. During a subsequent interview on 5/14/26 at 10:09 a.m., the administrator stated she incorrectly identified RN-A, but instead staff licensed practical nurse (LPN)-A assisted to lift R1 from the floor. During an interview on 5/14/26 at 10:13 a.m., the LPN-A stated when a resident was found on the floor, staff assisted the resident off the floor, “Per facility protocol.” The LPN-A stated when she found R1 on the floor, she called for NA-D to help. The LPN-A stated she followed facility protocol to assist the resident from the floor with another staff and a gait belt. The LPN-A stated during orientation she was trained to assist a resident off the floor with a Hoyer but used her nursing judgment to get R1 off the floor with a two-person assistance instead. During an observation with the physical therapy assistant (PTA)-A on 5/14/26 at 10:40 a.m. of the video from the camera in R1's room dated 3/30/26 at 8:17 p.m., PTA-A acknowledged staff assisted R1 off the floor with a two-person lift instead of with a Hoyer lift. Additionally, upon review of another video from the same camera dated 4/3/26 at 8:14 p.m., staff utilized a Stand Aid with R1 and did not use a gait belt around R1 to assist with a lift from the wheelchair to a standing position but should have. With the position of the resident on the Stand Aid, the resident could have fallen backwards and staff would not have been able to stop the fall without the gait belt. During an observation with the administrator and clinical director (CD)-A on 5/14/26 at 11:00 a.m., of the video from the camera in R1’s room dated 4/3/26 at 8:14 p.m., revealed staff transferred R1 with a Stand Aid without using a gait belt around R1, and staff used R1’s hands to pull R1 to a standing position. During an interview on 5/14/26 at 11:00 a.m., both the administrator and CD-A were present. The administrator acknowledged staff did not utilize a gait belt during the Stand Aid transfer, but should have. The CD-A acknowledged all nursing staff were trained about safe transfers and knew what they were supposed to do but had not performed R1's transfer from the chair safely and had not safely assisted R1 from the floor. During an interview on 5/14/26 at 1:07 p.m., the	F0689		06/19/2026

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F0689 SS = D	Continued from page 10 director of nursing (DON) and administrator identified the staff who transferred R1 without a gait belt on the Stand Aid as NA-A and NA-B. During an interview on 5/14/26 at 1:34 p.m., the nursing assistant (NA)-A stated staff were trained to use a gait belt around the resident's waist when using a Stand Aid. The NA-A stated she was not sure what other staff did, but she preferred to transfer R1 with a two-person, without the Stand Aid. When R1 declined to use a Stand Aid, the NA-A would tell the nurse and then used a two person transfer instead. The NA-A stated she just did what the resident wanted. Further, the NA-A stated sometimes R1 could help stand herself up, and sometimes she could not. The NA-A acknowledged R1 could not make decisions about her own safety due to her diagnosis of dementia. During an interview on 5/14/26 at 1:49 p.m., NA-B stated the correct way for staff to utilize a Stand Aid with a resident was to use a gait belt when assisting the resident to stand. During an interview on 5/14/26 at 1:48 p.m., the DON stated the facility policy indicated when a resident fell, staff would utilize a Hoyer lift if space allowed, and R1’s room contents could have been adjusted to allow for Hoyer use. When using a Stand Aid, staff were expected to use a gait belt around the waist of the resident so staff could help support the resident if the resident was unable to stand without assistance and to prevent falls. The Safe Resident Handling Program (SRHP) policy dated 7/7/25, indicated the SRHP provided interventions to provide caregivers the guidance for type of equipment, type of size of sling, and number of people to safely complete mobility tasks. The Stand Aid was used for residents who demonstrated leg strength for weight-bearing and were able to hold their torso in an upright position and pull themselves to a standing position. The responsibility of the staff was to eliminate manual lifting whenever possible by utilizing equipment and safe lifting practices.	F0689		06/19/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/13/26 and 5/14/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued: H52791621C (2992414).	20000		06/05/2026

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/14/2026**

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20000	Continued from page 1 As a result of the investigation a licensing order was issued at 0565. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		06/05/2026
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	20565	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction	06/19/2026

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20565	Continued from page 2 Based on interviews, observation, and document review the facility failed to implement care plan interventions for 1 of 3 residents (R1) when staff transferred R1 with pivot transfers (technique for moving a resident from one position to another. While standing, resident moves their feet to turn toward the new surface) instead of with the Stand Aid (non-motorized device to assist a person to a standing position), as indicated in the care plan. Findings include: R1's admission Minimum Data Set (MDS) dated 3/26/26 indicated R1 admitted to the facility on 3/20/26, was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included fractures, dementia and multiple traumas. R1's care plan dated 3/23/26 indicated R1 required assistance of one staff for toileting and transferred with a Stand Aid. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she was concerned about the way staff transferred R1. R1 was transferred by two people moving R1 instead of the machine [stand aid] staff were supposed to use. FM-A stated she had videos of R1's transfer from the toilet to the wheelchair, and from the wheelchair to the bed, indicating staff did not use the stand aid for transfers. During an interview on 5/13/26 at 3:56 p.m., the nursing assistant (NA)-D stated she did not recall how R1 was supposed to transfer, but staff would refer to the therapy book on the counter of the nurses' station to know how each resident was supposed to transfer. During an interview on 5/13/26 at 4:04 p.m., NA-C stated she was supposed to use the Stand Aid to transfer R1. The NA-C stated she always used the Stand Aid with R1 and did not transfer R1 without it because R1 could fall using a pivot transfer. During an interview on 5/13/26 at 4:44 p.m., the administrator stated R1's care plan indicated R1 required use of the stand aid and staff assistance for transfers. During an interview on 5/13/26 at 4:49 p.m., the registered nurse (RN)-A stated she did not remember R1. The RN-A stated a resident's care plan directed staff in how to transfer a resident safely and it was	20565	Continued from page 2 constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. R1 was discharged from facility at time of survey. All residents have the potential to be affected by this deficient practice. To identify residents at potential risk, DNS or designee will observe residents requiring transfers using mechanical lift or stand aids according to care plans and ensure staff conduct transfers as care plan directs at time of observation. To ensure deficient practice will not recur, education on policies: Care Plans will be provided to all staff by the Director of Nursing Services or designee via in-person training by 6/19/2026 or prior to next working shift. To ensure compliance is maintained, the DNS/designee will complete random audits of resident transfer and cares weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations. Compliance date 6/19/2026.	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/14/2026**

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20565	Continued from page 3 unsafe to transfer a resident with a pivot transfer instead of a Stand Aid if the therapy department directed staff to use a Stand Aid. During an interview on 5/14/26 at 10:13 a.m., the licensed practical nurse (LPN)-A stated when a resident's care plan indicated transfer with a Stand Aid, staff should transfer with a Stand Aid. R1 required the Stand Aid because she could not bear weight on both legs. During an observation with the physical therapy assistant (PTA)-A on 5/14/26 at 10:40 a.m., upon review of the video footage from the camera in R1's room, dated 4/4/26 at 8:17 p.m., revealed two staff pivot transferred R1 from the toilet to her wheelchair. The two staff did not use the Stand Aid. The PTA-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 10:40 a.m., the PTA-A stated R1 was supposed to be transferred with a Stand Aid, and not with a two-person pivot transfer. The transfers on the video footage was not completed according to R1's care plan. Further, the PTA-A stated the therapy department kept a book at the nurses' station which gave direction how each resident was supposed to be transferred. The PTA-A stated R1 was supposed to transfer with the Stand Aid. During an observation with the administrator and clinical director (CD)-A on 5/14/26 at 11:00 a.m., upon review of the video dated 4/4/26 at 8:17 p.m., revealed two staff pivot-transferred R1 from the toilet to her wheelchair instead of using a Stand Aid. The administrator and CD-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 11:00 a.m., the CD-A stated he did not see a Stand Aid in the videos. If the care plan indicated staff were supposed to use a Stand Aid, they should have used a Stand Aid for safety to ensure the resident did not fall. During an interview on 5/14/26 at 1:07 p.m., the director of nursing (DON) and administrator identified the staff from the two videos who transferred R1 from the toilet to the wheelchair and the wheelchair to the bed without a Stand Aid as NA-C and NA-D.	20565		06/19/2026

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20565	Continued from page 4 During an interview on 5/14/26 at 1:34 p.m., the NA-A acknowledged she worked on 4/4/26 and assisted another staff to transfer R1 with a gait belt from the toilet to the wheelchair. The NA-A was aware R1's care plan indicated use the Stand Aid. The NA-A stated the Stand Aid was not used because R1 wanted to transfer with the gait belt instead. The NA-A stated she preferred to transfer residents with a pivot transfer and gait belt instead of using a Stand Aid, but sometimes R1 was able to stand and sometimes could not. R1 was not always able to remember to stand because R1 had dementia. The NA-A stated if the resident did not want to follow the care plan and use the Stand Aid, the NAs could talk to the nurse and use a two-person assist for transfers instead of following the care plan. During an interview on 5/14/26 at 1:49 p.m., NA-B stated she did not remember working with R1. To know how a resident was supposed to transfer, staff referred to the therapy book at the nurses' station or asked another staff who knew the resident. During an interview on 5/14/26 at 1:48 p.m., the DON stated R1 was supposed to transfer with a Stand Aid and one staff per R1's care plan. Therapy staff determined the residents' ability to transfer and put each resident's transfer status in the therapy book at the nurses' station. If a resident did not choose to follow the care plan the NA would ask a nurse for help to educate the resident about the risks and benefits of not following the care plan for safe transfers. When a resident has dementia, staff should attempt to perform the transfer according to the care plan for safety to prevent falls. The Care Plan for Therapy and Rehab policy dated 12/1/25 indicated the care plan used to provide guidance to the interdisciplinary team. The Safe Resident Handling Program (SRHP) policy dated 7/7/25 indicated the SRHP provided interventions to provide caregivers the guidance for type of equipment, type of size of sling, and number of people to safely complete mobility tasks. The Stand Aid was used for residents who demonstrated leg strength for weight-bearing and were able to hold their torso in an upright position and pull themselves to a standing position. The responsibility of the staff was to eliminate manual lifting whenever possible by utilizing equipment and safe lifting practices.	20565		06/19/2026

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20565	Continued from page 5 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are implemented for residents who require lifts for transfers. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	20565		06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING	**06/02/2026**

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GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422**

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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on June 2, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Specialty Care Community, 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		07/10/2026

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: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - MAIN BLDG** B. WING	(X3) DATE SURVEY COMPLETED **06/02/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422**

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K0000 Bldg. 02	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. Building Info: Good Samaritan Society - Specialty Care Community is a 3-story building with a basement that was built in 2012 and determined to be Type II (111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with complete smoke detection that is monitored for automatic fire department notification. The facility has a capacity of 96 beds and had a census of 89 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		07/10/2026
K0918 SS = F Bldg. 02	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K0918	K0918 (SS=F): Electrical Systems – Annual Fuel Testing Survey cited missing documentation of annual	07/10/2026

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K0918 SS = F Bldg. 02	Continued from page 2 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain 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 8.3.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 6/2/2026, at 11:15 AM, it was revealed by a review of available documentation, the facility did not have documentation on the annual fuel testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918	Continued from page 2 generator fuel testing. Annual fuel testing for the emergency generator was completed on 6/8/2026. Documentation of testing was obtained and placed in the facility maintenance compliance binder. All residents residing in the facility had the potential to be affected by this deficient practice due to reliance on the Emergency Power Supply System during a power outage. No residents were negatively impacted by this deficient practice. To ensure the deficient practice will not recur, education was provided to the Maintenance Director and designee on 6/25/2026 regarding required EPSS testing and documentation, including annual fuel quality testing per NFPA requirements. A preventive maintenance tracking system was updated to include annual fuel testing due dates and documentation requirements. To ensure compliance is maintained, the Maintenance Director or designee will audit emergency generator compliance documentation weekly x 4 and monthly x 3 to ensure all required testing is completed and documented timely. Audit results will be reviewed through QAPI for further recommendations. Compliance date: 7/10/2026	07/10/2026

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K0353 SS = E Bldg. 02	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 25 (2011 edition) (5.2.2.2). This deficient finding could have a moderate impact on the residents within the facility. Findings include: On 6/2/2026, at 12:15 PM, it was revealed by observation that at the entrance to the Arrowhead Unit, there were wires in contact with the sprinkler system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	K0353 (SS=E): Sprinkler System – Wires Touching Sprinkler Pipe Survey cited wires in contact with sprinkler system at Arrowhead Unit entrance. The wires in contact with the sprinkler system at the entrance to Arrowhead Unit will be removed/resecured to maintain required clearance by 7/10/2026. All residents residing in the facility had the potential to be affected by this deficient practice. A facility-wide inspection of sprinkler piping and surrounding areas will be completed by 7/10/2026 to identify any additional obstructions or contact points. No additional concerns were identified / Additional concerns were corrected immediately. To ensure the deficient practice will not recur, education was provided to maintenance staff on 6/25/2026 regarding maintaining required clearances around sprinkler components and identifying environmental hazards that could interfere with fire suppression systems. To ensure compliance is maintained, the Maintenance Director or designee will conduct environmental audits of sprinkler system clearance weekly x 4 and monthly x 3. Findings will be reported to QAPI for follow-up as needed. Compliance date: 7/10/2026	07/10/2026
K0362 SS = E Bldg. 02	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING	K0362	K0362 (SS=E): Corridor Walls / Firewall Penetrations Survey cited two firewall penetrations (Boundary and Bluff Country units). The two identified firewall penetrations at Boundary Unit and Bluff Country Unit were sealed with	07/10/2026

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K0362 SS = E Bldg. 02	Continued from page 4 Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas in accordance with the Life Safety Code NFPA 101 - 2012 edition 19.3.6.2. This deficient finding could have a moderate impact on the residents within the facility. Findings Include: On 6/2/2026, at11:45 AM, observations and staff interview revealed that there were 2 firewall penetrations, 1 at the entrance to the Boundry Unit and 1 at the Bluff Country Unit. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0362	Continued from page 4 approved fire-rated materials on 6/2/2026. All residents residing in the facility had the potential to be affected by this deficient practice. A facility-wide inspection of fire-rated walls and penetrations will be completed by 7/10/2026 to identify additional penetrations. Any identified penetrations were repaired immediately. To ensure the deficient practice will not recur, education was provided to maintenance staff on 6/25/2026 regarding identification of wall penetrations and maintaining fire barrier integrity. To ensure compliance is maintained, the Maintenance Director or designee will complete fire barrier audits weekly x 4 and monthly x 3. Results will be reviewed in QAPI for further recommendations. Compliance date: 7/10/2026	07/10/2026
K0293 SS = D Bldg. 02	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K0293	K0293 (SS=D): Exit Signage Survey cited missing “Not an Exit” sign on Arrowhead Patio access door. A “Not an Exit” sign will be installed on the Arrowhead Patio access door by 7/10/2026 . All residents residing in the facility had the potential to be affected by this deficient practice. A facility-wide audit of exit and directional signage	07/10/2026

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K0293 SS = D Bldg. 02	Continued from page 5 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed maintain the egress requirements in accordance with NFPA 101, 7.10.8.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 6/2/2026, at 11.30 AM, observations and staff interview revealed that the access door to the Arrowhead Patio did not have the required "Not an Exit" sign. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0293	Continued from page 5 was completed on DATE to identify missing or noncompliant signage. Any identified concerns were corrected immediately. To ensure the deficient practice will not recur, education was provided to maintenance staff on 6/25/2026 regarding required exit and directional signage and egress requirements per Life Safety Code. To ensure compliance is maintained, the Maintenance Director or designee will complete exit signage audits weekly x 4 and monthly x 3. Results will be reviewed through QAPI for follow-up as needed. Compliance date: 7/10/2026	07/10/2026
K0324 SS = D Bldg. 02	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K0324	K0324 (SS=D): Cooking Facilities – Missing 120-Minute Stove Timer Survey cited missing 120-minute timer on therapy/rehab stove. A compliant 120-minute timer will be installed on the stove in the Therapy and Rehab space by 7/10/2026. All residents residing in the facility had the potential to be affected by this deficient practice. A facility-wide audit of all resident-accessible cooking appliances will be completed on 7/10/2026 to ensure required safety devices were installed and functioning properly. Any identified concerns were corrected immediately. To ensure the deficient practice will not recur, education was provided to maintenance staff and department leaders on 6/25/2026 regarding cooking equipment safety requirements, including timer requirements for resident-accessible cooking appliances. To ensure compliance is maintained, the Maintenance Director or designee will audit cooking equipment safety weekly x 4 and monthly x 3. Audit findings will be brought to QAPI for further	07/10/2026

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K0324 SS = D Bldg. 02	Continued from page 6 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed install the required 120 minute timer accordance with NFPA 101, 19.3.2.5.3 (9). This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 6/2/2026, at 12:15 PM, observations and staff interview revealed that the stove within the Therapy and Rehab space did not have the required 120 minute time installed to safeguard the stove. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0324	Continued from page 6 recommendations. Compliance date: 7/10/2026	07/10/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 24, 2026

Administrator
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY
3815 WEST BROADWAY AVENUE
ROBBINSDALE, MN 55422

RE: CCN: 245279
Cycle Start Date:

Dear Administrator:

On June 23, 2026 we notified you a remedy was imposed. On

On July 23, 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 13, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 14, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 23, 206, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 14, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 13, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,



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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 24, 2026

Administrator
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY
3815 WEST BROADWAY AVENUE
ROBBINSDALE, MN 55422

Re: Reinspection Results
Event ID: 231A73-L2

Dear Administrator:

On July 23, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 4, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING B. WING	06/04/2026

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E0000	Initial Comments On 6/1/26 - 6/5/26 , a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		07/10/2026
F0000	INITIAL COMMENTS On 06/01/26 through 06/04/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed and found to be Unsubstantiated: H5279616C (2992047). NO citations were issued. H52792618C (2980235). However, F657 was cited. H52792619C (2980218). However, F657 was cited. H52792620C (2979001). NO citations were issued. H52792621C (2710080). NO citations were issued. H52792622C (2664767). NO citations were issued. The following complaints were reviewed and found to be Substantiated: H5479623C (3009703). NO licensing orders were issued. H5279614C (3006755). NO licensing orders were	F0000		07/10/2026

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

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F0000	Continued from page 1 issued. H52792617C (2981289). NO licensing orders were issued. H52792625C (2627017), with F628 being cited. 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. t the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F0000		07/10/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff consistently wore hair restraints and gloves while serving food. Additionally, the facility failed to maintain food temperatures within the desired range. The facility also failed to consistently cover food items placed in	F0812	F812 (S/S = F): Food Procurement: Store/Prepare/Serve-Sanitary All residents have the potential to be affected by this deficient practice. Education immediately provided to staff on wearing hair restraints and gloves while serving food, and checking food temperatures to ensure they’re within the desired range. Also, immediate education was provided on covering and dating food items placed in the freezer. All residents have the potential to be affected by this deficient practice. A complete kitchen audit was completed to ensure staff were wearing hair restraints and gloves while serving food and checking food temperatures to ensure they’re within the desired range. Also, education was provided on covering and dating food items placed in the freezer. To ensure deficient practice will not recur, all dining staff will be educated on policies Employee Hygiene and Dress Code – Food and Nutrition Services and Hand Washing and Glove Use – Food and Nutrition Services was completed with dietary staff on 6/2/2026. Specifically, education will focus on wearing hair restraints and gloves while serving food, and checking food temperatures to ensure they’re within the desired range. Also, education will focus on covering and dating food items placed in the freezer. To ensure systemic changes are sustained, the Dietary Manager will review dress code expectations and food storage requirements at monthly department meetings until compliance is sustained.	07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0812 SS = F	Continued from page 2 the freezer and date the items with the date placed and the date food items were to be used by. This had the potential to affect all 88 residents who resided at the nursing home. Findings include: On 6/1/26 at 5:11 p.m., dietary aide (DA)-A was observed setting up kitchenette area for evening meal service. DA-A had her hair pulled back in a ponytail, with strands of hair hanging free from the ponytail on the sides of her head. DA-A was wearing a standard uniform top. Further, Dietary manager (DM)-A delivered a tray of sherbet to the kitchenette without a hair net in place. At this time, DA-A removed the aluminum foil from the chafing dishes, stirred the chicken noodle soup, and began to prep for food service. DA-A applied a glove on the hand which handled the bread for the egg salad sandwich. DA-A removed the glove and replaced it with another glove, however, did not perform hand hygiene in between. At 5:16 p.m. DA-A had gloves on both hands while she removed the crusts from bread to prepare a sandwich. At 5:17 p.m., DA-A removed the second glove and did not perform hand hygiene. On 6/1/26 at 5:19 p.m., DA-A proceeded to check temperature of food items. DA-A reported the temperature of the egg salad filling for sandwiches was 56.8 degrees Fahrenheit (F). The egg salad sandwich filling was observed to be in a stainless serving container, sitting on the counter, and was not placed in an ice bath. DA-A also checked the temperature of the mashed potatoes and reported them to be at 115.5 degrees Fahrenheit. DA-A stated she was unaware of what temperatures food items were to be at. On 6/1/26 at 5:21p.m., DM-A returned to the kitchenette, wearing a hairnet, covered by a cloth visor. DM-A had brought out an apron for DA-A to wear. DM-A was informed of food temperature of egg salad filling and removed food item to take down to kitchen to chill. On 6/1/26 at 5:28 p.m., DA-A stated if staff wore a ponytail holder, a hairnet was not needed. DA-A stated her hair had not fallen out of the ponytail holder. DA-A stated she did not typically use a hairnet as she pulled her hair back into a ponytail. On 6/1/26 at 5:39 p.m., egg salad filling was brought back up to kitchenette in the stainless-steel serving container, placed in an ice bath. DM-A stated this was “blast chilled”, placed in a salted ice	F0812	Continued from page 2 To ensure compliance is maintained, random audits of temperature logs and meal service by the Administrator or designee weekly x 4 and monthly x 3 to ensure temp logs are completed accurately and hair nets/gloves are used appropriately. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0812 SS = F	Continued from page 3 bath, while in freezer. The egg salad filling was temped at this time and was noted to be at 36.4 degrees F. DM-A stated temperature of cold food should be 40 degrees or less. DM-A stated there was no concern regarding salmonella for residents who had previously received sandwiches prior to temping as the filling was not out long enough in the “danger zone”. The potatoes were temped again at this time upon request and were noted to be at 160 degrees F. DM-A stated all hot food should be at 145 degrees F. DM-A stated when aware potatoes were at 116 degrees F., they should have been pulled, and a fresh batch made. DM-A stated she had realized she was not wearing a hairnet when delivering sherbet and went to obtain one. DM-A stated she had not noticed DA-A was not wearing a hairnet but should be. DM-A stated a hairnet was to be used to keep hair out of food. DM-A stated the expectation for those behind the serving line was to wear hairnets, aprons, and gloves on both hands. DM-A stated a ponytail was not adequate as a hair restraint. On 6/4/26 at 8:54 a.m., an observation was made during the breakfast service process in which DA-B was served breakfast while wearing a stocking cap which ended just under ears, and his hair was shoulder length and extended down to the neckline of shirt. On 6/4/26 at 9:35 a.m., DM-A stated DA-B should have worn a hairnet underneath the knit cap to restrain hair extending beyond the edge of the cap. The facility policy, Food Temperature Monitoring-Food and Nutrition Services, reviewed/revised 3/23/26, identified food temperatures are taken and recorded before each meal service. The policy also identified temperatures are taken at other times during or at the end of meal service to ensure temperatures are held within acceptable ranges. The policy indicated that food was served at proper serving temperatures, and further identified proper temperatures as below 41 degrees Fahrenheit for cold foods or above 135 degrees Fahrenheit for hot foods. The facility policy, Employee Hygiene and Dress Code-Food and Nutrition Services, reviewed/revised 5/27/25, identified hairnets or hair restraints and beard nets or beard restraints were to be used when cooking, preparing, assembling food or ingredients. This includes dish rooms and storage areas. See specific state guidelines. Hair is to be covered completely. The policy further states aprons are to	F0812		07/10/2026

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F0812 SS = F	Continued from page 4 be put on a clean apron at the beginning of each shift. The facility policy, Hand Washing and Glove Use-Food and Nutrition Services, reviewed/revised 6/6/25, hands are washed thoroughly before putting gloves on and after taking gloves off. On 6/1/26 at 1:06 p.m. initial kitchen tour was conducted with dietary manager (DM)-A. The walk-in freezer had egg rolls on second shelf on right side of freezer. The egg rolls were wrapped with plastic wrap with one end opened to the air of the freezer. There was no date on the plastic wrap. There was a package of unidentified meat wrapped with aluminum foil, there was no date observed on the package. The walk-in cooler had a jar of Grey Poupon mustard with no date opened indicated, In addition there were hot dogs wrapped with plastic wrap and no date indicated on the wrap. On a shelf below a counter there was a large plastic tub of panko that was not dated when opened and placed into the plastic tub. DM-A stated items were expected to have an opened date and placed into appropriate containers; there was to be no items left open to the air. On a follow-up visit to the kitchen on 6/3/26 at 12:28 p.m. there was an opened undated package of pizza crust and a plastic bag of carrots in the walk-in freezer. DM-A stated the staff were usually good about dating items when opened. Facility Food-Supply Storage–Food and Nutrition Services policy dated 3/13/26 indicated foods that had been opened or prepared were placed in an enclosed container, dated, labeled and stored properly.	F0812		07/10/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	F880 (S/S = F): Infection Prevention/Control All residents have the potential to be affected by this deficient practice. Immediately IP nurses reviewed all	07/10/2026

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F0880 SS = F	Continued from page 5 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	Continued from page 5 residents not currently being treated with antibiotic therapy or other treatment for signs and symptoms of illness/infections as identified. All residents have the potential to be affected by this deficient practice. Facility reviewed all residents for signs/symptoms of illness and infection. To ensure deficient practice will not recur, The DNS/designee will educate all staff on Infection policy Identification/Surveillances, Management, and Reporting of Suspected/Confirmed Infections will be completed with all nursing staff by 7/10/2026. To ensure systemic changes are sustained, the DNS/designees will review all infection control tracking in the weekly IDT meeting to include routine surveillance of signs and symptoms of illness/infections which are not currently being treated with antibiotic therapy or other treatment To ensure compliance is maintained, random audits newly identified signs/symptoms of infection will be completed by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to ensure routine surveillance is completed. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0880 SS = F	Continued from page 6 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to implement routine surveillance of signs and symptoms of illness/infection which were not currently being treated with antibiotic therapy or other treatment. This had the potential to impact all 88 residents who resided at the facility, as well as staff, and visitors. Findings include: A review of the Infection Surveillance Reports was completed for the months of March, April, and May of 2026. The documents included the total number of infections, whether facility or community acquired infections, the facility acquired infection incidence rates, and the number of multidrug resistant organisms (MDROs). The surveillance logs further classified the types by category of infection. The data gathered on this log included resident name, room number, infection type, signs and symptoms reported, and status (active or resolved). The log also included the type of treatment or antibiotic, antifungal or antimicrobial in place. The log lacked identification of completed testing (labs, chest x-ray, etc.). Although the logs contained an area for comments, this area was not utilized for reporting any completed lab results. During interview on 6/3/26 at 2:07 p.m., the Infection Preventionist (IP), also director of nursing (DON), stated she currently used the Point Click Care electronic medical record (EMR) for surveillance tracking. IP stated the PCC EMR was able to pull	F0880		07/10/2026

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F0880 SS = F	Continued from page 7 data up and input the information into the Infection Surveillance Report. The log lacked capability to pull testing and lab results into the form as they were not hyperlinked to the surveillance report. IP stated this information may be entered into the comment section, however, had not implemented this process. The infection control surveillance log lacked tracking instances of signs and symptoms presented which were not being treated with antibiotics, antifungals, or antimicrobials. IP stated although not tracked on the surveillance log, signs and symptoms of potential illness or infections were reviewed daily Monday through Friday by running reports and reviewing the documentation based on the control “f” (find) feature of the progress notes. IP stated when she reviewed the progress notes, she looked for things such as an increase or decrease in temperatures and vital signs, symptoms of cough, shortness of breath, altered respiratory status, nausea, vomiting and diarrhea. The progress notes were also monitored for new admissions, indwelling devices, history of MDRO’s, and new wounds. In addition to symptoms of illness/infection, a review of new orders was also completed. Upon demonstrating this process for the day of interview, the report generated 99 pages. Although the information was culled out for the day of review, this data was not recorded or compiled for subsequent review for trending of current trends of symptoms (urinary tract infections, upper respiratory symptoms, or gastrointestinal symptoms) or tracking for patterns of symptoms or trending of illnesses. IP stated she monitored the daily progress notes for symptoms of upper respiratory infections and if symptoms were noted, testing would be performed. IP stated the same process was used for symptoms of vomiting or diarrhea, and testing for c. diff (clostridium difficile). IP stated there were no formalized logs of those who were currently being monitored only and that data was captured only by running daily reports or review of individual progress notes. At the time testing was performed due to persistent symptoms, the individual would then be tracked on the “suspected” log. IP acknowledged the benefit of monitoring via the surveillance log signs and symptoms of infections and illness to capture any potential trends which would allow the opportunity to implement training, education, and placement of interventions to help decrease the potential for spread of illness and infection. The facility policy, Infection Prevention and Control Program, All Service Lines-Enterprise,	F0880		07/10/2026

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F0880 SS = F	Continued from page 8 reviewed/revised 3/25/26 identified the purpose of the infection control program was to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable diseases and infections. The policy identified the surveillance system was to be implemented to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable diseases and infections.	F0880		07/10/2026
F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.	F0605	F605 (S/S = E): Right to be Free from Chemical Restraints Orthostatic blood pressure monitoring for R7 was completed on 6/5/2026. Orthostatic blood pressure monitoring for R10, R41, and R91 were completed on 7/1/2026. All residents that have an order for psychotropic medications have the potential to be affected by this practice. Those with psychotropic medications had side effect monitoring completed by 7/1/2026 and those on anti-psychotic medications had orthostatic blood pressure orders completed on 7/1/2026. To ensure deficient practice will not recur, education on policy Psychotropic Medications was completed with nursing staff on 6/30/2026. DNS or designee will initiate a review during clinical meetings weekly reviewing psychotropic side effect monitoring ensure orthostatic blood pressure orders initiated as needed. To ensure compliance is maintained, random audits of orthostatic blood pressures and side effect monitoring by the DNS or designee weekly x 4 and monthly x 3 to ensure concerns are addressed in a timely manner. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0605 SS = E	Continued from page 9 . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F0605		07/10/2026

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F0605 SS = E	Continued from page 10 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure residents receiving psychotropic medications were adequately monitored for potential adverse consequences, including failure to implement side effect monitoring for 4 of 6 residents (R7, R10, R41, and R91) reviewed for psychotropic medication monitoring, and failure to obtain and document orthostatic blood pressures as ordered for 3 of 6 residents (R10, R41, and R91) reviewed for psychotropic medication use. Findings include: R7 R7's comprehensive Minimum Data Set (MDS) dated 5/4/26, identified R7 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R7's diagnoses included deep vein thrombosis (DVT; a blood clot that forms in a deep vein, usually in the leg), hypertension (high blood pressure), benign prostatic hyperplasia (BPH; enlargement of the prostate gland that can affect urination), renal insufficiency (reduced kidney function), diabetes mellitus (a condition in which the body has difficulty regulating blood sugar levels), and cerebrovascular accident (CVA; a stroke caused by interrupted blood flow to the brain). The MDS further identified R7 received psychotropic medications.	F0605		07/10/2026

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F0605 SS = E	Continued from page 11 R7's physician orders identified Escitalopram Oxalate Oral Tablet 20 mg (milligram) by mouth one time a day for depression, initiated on 1/14/25. R7's electronic health record (EHR) failed to identify evidence side effect monitoring had been implemented to assess for potential adverse consequences related to the psychotropic medication. R10 R10's comprehensive MDS dated 4/6/26, identified R10 had severe cognitive impairment and required assistance with ADL's. R10's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by a physical injury), atrial fibrillation (an irregular and often rapid heart rhythm), hypertension (high blood pressure), and non-Alzheimer's dementia (a decline in memory, thinking, and reasoning abilities not caused by Alzheimer's disease). The MDS further identified R10 received antipsychotic medications. R10's physician orders identified Brexpiprazole Oral Tablet 1.5 mg by mouth two times a day for agitation related to dementia, initiated on 3/23/26, and Haloperidol 2 mg by mouth one time a day for delusions related to unspecified dementia, initiated on 6/1/26. R10's EHR failed to identify evidence side effect monitoring had been implemented to assess for potential adverse consequences related to the antipsychotic medications. R10's physician orders further identified an order to document orthostatic blood pressure one time a day, starting on the 1st and ending on the 1st of every month, for antipsychotic medication monitoring, including blood pressure and pulse readings in the lying, sitting, and standing positions. The order was initiated on 4/1/26. Review of orthostatic blood pressure documentation identified: • 4/1/26: Lying blood pressure was documented as 110/76 with pulse 72. Sitting and standing blood pressures were both documented as 118/70 with pulse 90. • 5/1/26: Lying, sitting, and standing blood pressures were all documented as 120/66 with pulse 90.	F0605		07/10/2026

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F0605 SS = E	Continued from page 12 • 6/1/26: Lying, sitting, and standing blood pressures were all documented as 147/98 with pulse 98. R10's EHR failed to identify evidence orthostatic blood pressures were obtained as ordered. The identical blood pressure and pulse readings documented for multiple positions called into question whether separate measurements were obtained in the lying, sitting, and standing positions. R41 R41's quarterly MDS dated 5/26/26 identified R41 had severe cognitive impairment and required assistance with ADL's. R41's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by a physical injury), hypertension (high blood pressure), peripheral vascular disease (PVD; a condition involving reduced blood flow through blood vessels outside of the heart and brain), hyperlipidemia (elevated levels of fats, such as cholesterol and triglycerides, in the blood), arthritis (inflammation or degeneration of the joints causing pain and stiffness), Alzheimer's disease (a progressive brain disorder that affects memory, thinking, and behavior), stroke (damage to the brain caused by interrupted blood flow), and non-Alzheimer's dementia. The MDS further identified R41 received antipsychotic medications. R41's physician orders identified risperidone Oral Tablet 0.25 mg by mouth three times a day for hallucinations, initiated on 5/8/26. R41's EHR failed to identify evidence side effect monitoring had been implemented to assess for potential adverse consequences related to the antipsychotic medication. R41's physician orders further identified an order to document orthostatic blood pressure one time a day, starting on the 3rd and ending on the 3rd of every month, for antipsychotic medication monitoring, including blood pressure and pulse readings in the lying, sitting, and standing positions. The order was initiated on 2/3/26. Review of orthostatic blood pressure documentation identified: • 2/3/26: Not obtained. Documentation indicated the resident refused. The record failed to identify evidence the monitoring was attempted again at a	F0605		07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0605 SS = E	Continued from page 13 later time. • 3/3/26: Sitting blood pressure was documented as 120/50 with pulse 82. Lying and standing blood pressures were both documented as 126/56 with pulse 76. • 4/3/26: Not obtained. Documentation indicated the resident refused. The record failed to identify evidence the monitoring was attempted again at a later time. • 5/3/26: Lying, sitting, and standing blood pressures were all documented as 112/70 with pulse 78. • 6/3/26: Lying, sitting, and standing blood pressures were all documented as 128/56 with pulse 72. R41's EHR failed to identify evidence orthostatic blood pressures were obtained as ordered. The identical blood pressure and pulse readings documented for multiple positions called into question whether separate measurements were obtained in the lying, sitting, and standing positions. R91 R91's quarterly MDS dated 3/23/26, identified R91 had severe cognitive impairment and required assistance with ADL's. R91's diagnoses included schizophrenia (a chronic mental health disorder that affects a person's ability to think clearly, perceive reality, manage emotions, and interact with others). The MDS further identified R91 received antipsychotic medications. R91's physician orders identified Olanzapine Oral Tablet 5 mg by mouth two times a day related to paranoid schizophrenia, initiated on 3/25/26 and discontinued on 6/1/26; Olanzapine Oral Tablet 2.5 mg by mouth two times a day related to paranoid schizophrenia, initiated on 6/1/26; and risperidone Oral Tablet 2 mg by mouth two times a day for paranoid schizophrenia, initiated on 6/9/25. R91's EHR failed to identify evidence side effect monitoring had been implemented to assess for potential adverse consequences related to the antipsychotic medications. R91's physician orders further identified an order to document orthostatic blood pressure one time a day, starting on the 17th and ending on the 17th of every	F0605		07/10/2026

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F0605 SS = E	Continued from page 14 month, for antipsychotic medication monitoring, including blood pressure and pulse readings in the lying, sitting, and standing positions. The order was initiated on 7/17/25. Review of orthostatic blood pressure documentation identified: • 1/17/26: Lying and sitting blood pressures were both documented as 136/78. No pulse readings were documented, and no standing blood pressure was documented. • 5/17/26: Lying, sitting, and standing blood pressures were all documented as 142/68 with pulse 66. R91's EHR failed to identify evidence orthostatic blood pressures were obtained as ordered. The identical blood pressure and pulse readings documented for multiple positions, as well as incomplete documentation, called into question whether separate measurements were obtained in the lying, sitting, and standing positions. During an interview on 6/4/26 at 9:41 a.m., licensed practical nurse (LPN)-B stated nurses or TMA's completed orthostatic blood pressure monitoring. LPN-B stated that for residents who were unable to stand, staff would obtain sitting and lying blood pressures. During an interview on 6/4/26 at 12:14 p.m., RN Case Manager (CM)-C stated orthostatic blood pressures should be completed monthly and include blood pressure measurements in the lying, sitting, and standing positions. CM-C stated orthostatic blood pressures were important because antipsychotic medications could cause side effects that increased a resident's risk for falls. CM-C stated they would not expect blood pressure readings to be exactly the same in all three positions because some variation would typically occur. CM-C further stated that if a resident refused the monitoring, staff should document the refusal and attempt the monitoring again later. CM-C reviewed the orthostatic blood pressure documentation for the identified residents and confirmed several readings were identical in all positions. CM-C stated they would ensure nursing staff were educated on the correct procedure for obtaining orthostatic blood pressures. During an interview on 6/4/26 at 12:59 p.m., a call was placed to the consultant pharmacist and a	F0605		07/10/2026

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F0605 SS = E	Continued from page 15 message was left requesting a return call regarding psychotropic medication monitoring and orthostatic blood pressure monitoring. As of survey exit, the consultant pharmacist had not returned the call. During an interview on 6/4/26 at 12:59 p.m., director of nursing (DON) stated psychotropic medication monitoring should be completed monthly and include blood pressure measurements in the lying, sitting, and standing positions. DON stated that if a resident refused the monitoring, staff should allow time, reapproach the resident, and, if the resident continued to refuse, reschedule the monitoring in the TAR and document the interventions attempted. DON stated staff would not expect blood pressure readings to be exactly the same in all three positions. During an interview on 6/4/26 at 1:16 p.m., CM-C stated the facility did not have anything in place for monitoring psychotropic medication side effects. CM-C stated there was no documentation of side effect monitoring for residents receiving psychotropic medications and acknowledged there probably should have been documentation so staff would know whether the medication was having a negative effect on the resident. During an interview on 6/4/26 at 1:29 p.m., DON stated documentation for monitoring medication side effects was something the facility was just beginning to implement. DON stated the facility had begun reviewing medication side effects during morning meetings. DON stated side effect monitoring was important so staff would know whether residents were experiencing adverse effects from psychotropic medications. The facility's "Psychotropic Medications – Rehab/Skilled" policy, reviewed/revised 12/9/25, identified that each resident's drug regimen must be free from unnecessary medications, including medications used without adequate monitoring or in the presence of adverse consequences that indicate the dose should be reduced or discontinued. The policy required ongoing monitoring throughout the administration of psychotropic medications, including continued mood and behavior documentation to evaluate the medication's effect on behaviors, monitoring for medication side effects, and monitoring for effectiveness and potential adverse consequences. The policy further directed nursing staff to document side effects, notify the physician and family/legal representative when side effects occurred or worsened, and complete ongoing assessments to evaluate resident response to	F0605		07/10/2026

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F0605 SS = E	Continued from page 16 psychotropic medications. The policy also required the reduction committee to review psychotropic medications at least every three months, including evaluation of target symptoms, medication effectiveness, and any medication-related adverse consequences experienced by the resident during the previous quarter.	F0605		07/10/2026
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to revise comprehensive care plans to reflect significant changes in resident status, conditions, preferences, and interventions, for 3 of 3 residents (R111, R7, and R75) reviewed for care plan revision. Further, the facility failed to update the care plan with specific interventions for 2 of 2 residents (R1 and R122) reviewed for privacy of care.	F0657	F657 (S/S = E): Care Plan Timing and Revision R1 and R122 were discharged at the time of survey. Care plans were updated for R111, R7, and R75 to reflect significant changes in resident status, conditions, preferences, and interventions on 6/15/26. All residents have the potential to be affected by this deficient practice. To prevent reoccurrence, residents with a significant change in the last 90 days were reviewed, and care plans were updated to reflect significant changes in resident status, conditions, preferences, and interventions by 7/1/2026. To ensure deficient practice will not recur, education on policy Care Plan was completed with nursing staff on by 7/10/2026. DNS or designee will initiate care plan revisions during morning clinical meetings as resident status, conditions, preferences and interventions are in need of revision. Quarterly care plan meetings will be utilized to review with resident and revise as needed. To ensure compliance is maintained, random audits of care plans of residents that have had a significant change or fall will be reviewed by the DNS or designee weekly x 4 and monthly x 3 to ensure concerns are addressed timely. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0657 SS = E	Continued from page 17 Findings include: R111 R111's discharge return anticipated MDS dated 5/15/26, identified R111 had moderate cognitive impairment and required assistance with ADLs. R111's diagnoses included cancer (a disease in which abnormal cells grow uncontrollably), septicemia (a serious bloodstream infection), and non-Alzheimer's dementia (a decline in memory and cognitive functioning not caused by Alzheimer's disease). The MDS further identified R111 was receiving hospice services. R111's EHR identified hospice services were discontinued on 5/11/26. R111's care plan printed of 6/2/26, identified a focus area which stated, "The resident has a terminal prognosis R/T prostate cancer E/B on Optage Hospice," with an initiation date of 12/9/25. However, the care plan continued to indicate R111 was receiving hospice services after hospice services were discontinued on 5/11/26 and failed to be revised to reflect the resident's discharge from hospice. R111's care plan printed 6/4/26, further identified "The resident requires Enhanced Barrier Precautions (EBP) R/T wound." R111's EHR identified the wound had healed and R111 remained on EBP due to the presence of a urinary catheter. The care plan failed to be revised to reflect the resident's current need for EBP precautions and continued to identify the healed wound as the basis for the intervention. R7 R7's comprehensive Minimum Data Set (MDS) dated 5/4/26 identified R7 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R7's diagnoses included diabetes mellitus (a chronic condition that affects how the body uses blood sugar) and cerebrovascular accident (CVA; damage to the brain caused by interrupted blood flow). The MDS further identified R7 received insulin, an anticoagulant, and an antidepressant. R7's care plan printed 6/2/26, identified a care plan focus titled, "The resident has respiratory infection: Influenza A," with an initiation date of 12/25/25. R7's electronic health record (EHR) failed to identify	F0657		07/10/2026

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F0657 SS = E	Continued from page 18 ongoing signs, symptoms, treatment, or diagnosis of Influenza A. The care plan continued to identify Influenza A as an active care plan focus despite resolution of the condition and failed to identify revision or discontinuation of the focus area. R75 R75's comprehensive MDS dated 4/13/26, identified R75 had severe cognitive impairment and required assistance with ADLs. R75's diagnoses included non-Alzheimer's dementia (a decline in memory and cognitive functioning not caused by Alzheimer's disease) and post-traumatic stress disorder (PTSD; a mental health condition that can develop after experiencing or witnessing a traumatic event). The MDS further identified R75 displayed physical and verbal behavioral symptoms directed toward others, as well as other behavioral symptoms not directed toward others, one to three days during the assessment period. The MDS also identified wandering behavior one to three days during the assessment period. R75's care plan printed 6/2/26, identified dining preference interventions indicating the resident preferred to sit alone during mealtimes and liked to sit in the dining room by the television next to the window. R75's EHR further identified behavior management interventions had been implemented, including placement of a bookshelf sticker on the resident's door and installation of a door chime to alert staff when residents entered or exited the room. Review of the care plan failed to identify either intervention. Observation on 6/2/26 at 12:13 p.m. identified R75 exited his room and sat at a dining room table with another resident while waiting for lunch. A door chime sounded when the resident's room door opened. Observation on 6/2/26 at 12:20 p.m. identified R75 ate lunch with two other residents and engaged in conversation with them. Observation on 6/2/26 at 12:22 p.m. identified another resident sat at the table with R75, and R75 greeted the resident. Observation on 6/3/26 at 8:13 a.m. identified R75 exited his room for breakfast and a door chime sounded when the door opened. R75 then sat in the dining room with two other residents in the main	F0657		07/10/2026

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F0657 SS = E	Continued from page 19 dining room. During an interview on 6/4/26 at 9:27 a.m., nursing assistant (NA)-E stated R111 was on hospice and was on EBP precautions due to having a urinary catheter. During an interview on 6/4/26 at 9:31 a.m., NA-D stated R75 was easily agitated and was protective of his personal space. NA-D stated a door chime alerted staff when the resident's door opened so staff could ensure other residents did not enter the room. NA-D further stated a bookshelf sticker had been placed on the resident's door approximately one month earlier. NA-D stated R75 initially sat in the small dining room when he was admitted to the facility but had been sitting in the main dining room with other residents for quite some time. NA-D also stated R7 had not been sick in "quite a while." During an interview on 6/4/26 at 9:33 a.m., licensed practical nurse (LPN)-B stated R111 had graduated from hospice services and the facility had discussed the possibility of restarting hospice services; however, R111 did not meet the criteria. LPN-B stated R111 was on EBP precautions due to a urinary catheter and had not had a wound for several months. R75 previously exhibited exit-seeking behaviors but had mellowed considerably and spent more time outside of his room. To address those behaviors, a door chime and bookshelf sticker had been implemented approximately one month earlier to alert staff if another resident wandered into R75's room. R7 had not had Influenza since the previous year. LPN-B stated care plans should be updated to reflect changes in resident conditions and interventions and could be updated by nursing staff, although the nurse manager completed most care plan revisions. During an interview on 6/4/26 at 12:32 p.m., registered nurse case manager (CM)-C stated R75 was territorial regarding his personal space and could be paranoid at times, although his behavior had improved. CM-C stated a bookshelf sticker and	F0657		07/10/2026

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F0657 SS = E	Continued from page 20 door chime had been implemented on 5/7/26 and had been effective interventions; however, neither intervention was included in the care plan. CM-C stated it was important for staff to be aware of the interventions and confirmed they should have been care planned. CM-C further confirmed R75 initially sat in the small dining room but currently sat in the main dining room with three other residents and stated the dining preference intervention should have been revised to reflect the resident's current preference. R111 was discharged from hospice services on 5/11/26 following hospitalization. CM-C reviewed the EHR and confirmed hospice services continued to be identified in the record and on the care plan despite the hospice discharge. CM-C further confirmed R111 no longer had a wound and remained on EBP precautions due to a urinary catheter and stated the care plan should have been revised to accurately reflect the resident's hospice status and current reason for EBP precautions. R7 no longer had Influenza A and that the care plan continued to identify Influenza A as an active respiratory infection despite the diagnosis occurring in 2025. CM-C stated the care plan should have been revised to remove the resolved condition. During an interview on 6/4/26 at 12:59 p.m., director of nursing (DON)-A stated hospice discharge notifications should prompt review and revision of the care plan and that a significant change MDS should be completed following discharge from hospice services. DON-A stated care plans should be updated whenever a resident experienced a new diagnosis, condition, intervention, preference change, or other significant change in status. DON-A further stated care plans served as the primary communication tool for staff and should accurately reflect the resident's current needs, interventions, and preferences to ensure staff understood how to provide appropriate care. The facility's policy, Care Plan - R/S, LTC, Therapy & Rehab, revised 12/1/25, indicated each resident would have an individualized, person-centered comprehensive care plan that addressed the resident's medical, nursing, physical, functional, emotional, psychosocial, and educational needs. The policy indicated care plans would be based on assessments, the Resident Assessment Instrument (RAI), physician orders, and identified resident	F0657		07/10/2026

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F0657 SS = E	Continued from page 21 problems, needs, and concerns. The policy further indicated the comprehensive care plan would be modified to reflect the care currently required and provided to the resident. Care plans were to be reviewed at least quarterly and reviewed, evaluated, and updated whenever there was a significant change in the resident's condition. R1 R1's significant change assessment of 3/24/26 indicated R1 had moderate cognitive impairment. The assessment identified R1 was able to communicate his needs and wishes and was able to understand information relayed to him. R1 was identified as needing assistance with activities of daily living (ADL's-dressing, grooming, and bathing). R1's medical diagnoses included headaches, cardiorespiratory debility (lack of function related to heart and respiratory problems), heart failure, hypertension (high blood pressure), renal chronic kidney disease (alteration in kidney function related to removal of waste through the kidney), diabetes (alteration in the way the body processes sugar), CVA (cardiovascular accident-stroke), hemiplegia/hemiparesis (loss of use/mobility of one side of the body), and anxiety. R1's care plan from admission of 1/3/26 lacked indication of use of camera, rationale for use, and placement by family for monitoring and interaction with R1. A facility document, titled Electronic Monitoring Notification and Consent Form (GSS 686) dated 11/17, identified R1 would like camera placed on 3/15/26, and would include video and audio. The form was not signed by family member and staff member until 4/6/26. R1's progress notes of 4/6/26, identified staff had discussed "video surveillance in progress" and provided the GSS 686 for completion. At that time the document was reviewed and completed with signatures of both family member and staff. The progress notes reflected a sign was placed on door to indicate to staff/visitors electronic monitoring was in place. R122 R122's Admission Profile indicated admission on 4/2/26, medical diagnoses included: Wernicke's encephalopathy (neurological symptoms (impaired	F0657		07/10/2026

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F0657 SS = E	Continued from page 22 vision and confusion) caused by lesions of the central nervous systems after exhaustion of B-vitamin reserves, alcohol dependence (in remission), anemia (low red blood cells or hemoglobin) and osteoarthritis (inflammation of joints). R122's care plan initiated 4/2/26, and last revised 4/24/26, lacked indication of use of video camera with audio capability for resident, as well as rationale for use, and other interventions related to this (signage, staff awareness, interaction with family through audio). A facility document, titled Electronic Monitoring Notification and Consent Form (GSS 686) dated 11/17, identified R122 would like camera placed on 4/6/26, and would include video and audio. The form was signed by family member and staff member on 4/6/26. R122's progress notes of 4/6/26, identified staff had discussed "video surveillance in progress" and provided the GSS 686 for completion. The note indicated staff member had left document for signature by family member. The documentation indicated once consent was signed, the camera was to be plugged in, and consent turned into the nurse's station. A copy of the signed consent was on file. A subsequent note of 4/10/26, indicated family was observing via camera and alerted staff of R122s need for help. During interview on 6/4/26 at 12:57 p.m. licensed social worker (LSW)-A, stated R1 had cameras found in his room without staff awareness. LSW-A stated family was contacted, a GSS-686 consent was completed, and the camera was put into place by family members. The appropriate signage was placed on the door to advise staff and visitors of the camera use. LSW-A stated the use of cameras should have been outlined in the care plan, and this task was the responsibility of the nurse manager in charge of R1's care. On 6/4/26 at 1:31 p.m. Social Services Director (SSD)-A stated the GSS 686 for R1 was obtained right away for consent for use of the camera, a sign was posted on the door, and administrative staff was notified. SSD-A stated R122's family member was contacted on 4/6/26 as well, and a consent was left for signature. The note left for family was to provide nursing staff with consent and were then able to proceed with use of the camera. SSD stated social services were responsible for obtaining the consent and posting the signage for camera use, however,	F0657		07/10/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422

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F0657 SS = E	Continued from page 23 nursing staff was responsible to update the care plan to reflect the use of the camera. On 6/4/26 at 10:55 a.m. registered nurse/clinical manager (CM)-B stated she was not working at the facility when the cameras were put into place. Both R1 and R122 had involved family members who had requested cameras to be put into use. CM-B stated signage was posted on the door to alert staff and visitors of the use of the camera. CM-B stated she had not completed the care plan process with R1 and R122. The facility policy, Electronic Monitoring in Resident/Client/Patient Rooms-Enterprise, date reviewed/revised 5/18/26, initially referred to a separate policy: Photography and Video Imaging, Patient, Visitor, Workforce Member-Enterprise. This policy is broken by states which allows this monitoring. The document reflects for Minnesota, “residents or, under certain circumstances, their authorized resident representative, may conduct electronic monitoring in a resident’s room or private living space after certain conditions are met (such as written consent and notification, including that of any roommate). The procedure identified the electric monitoring device may be used by the resident, or their authorized representative if appropriate, after requirements have been met. This includes review of information required, and signature of a consent to allow such use. The procedure directs staff to have signs posted to inform staff/visitors of use. The policy lacks indication regarding placing the information in the care plan, or subsequent documentation in follow up regarding ongoing use of the video camera. A review of the policy, Photography and Video Imaging, Patient, Visitor, Workforce Member-Enterprise, date reviewed/revised 5/18/26, was completed and also reviewed the perimeters in which this was allowed, along with consent required for use. The facility policy, Care Plan-R/S, LTC, Therapy and Rehab, date reviewed/revised 12/1/25, indicated that “each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident’s optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs.” The policy stated further: “This plan of care will be modified to reflect the care currently required/provided for the resident.”	F0657		07/10/2026

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F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to assure medication labels properly reflected provider orders for 2 of 7 residents (R110, R89) observed during medication administration. Findings include: On 6/1/26 at 4:10 p.m., medication observation was completed with licensed practical nurse (LPN)-A during R110's medication pass. LPN-A provided R110 with quetiapine fumarate 25 mg ½ tablet (1/2 tablet to total 12.5 mg-milligram/a unit of measurement) at that time, however, medication label read to give ½ tab(let) daily and went on to direct staff to give one tablet (25 mg) at bedtime. LPN-A stated medication administration record (MAR) directed staff to give at 4:00 p.m. LPN-A stated she was unsure if the previous dosing schedule had changed. LPN-A stated the medication label should match the orders on the MAR. LPN-A stated there were stickers available to place on the prescription	F0761	F761 (S/S = E): Label/Store Drugs and Biologicals R110 has discharged from the facility. The undated inhaler for R89 was disposed of, a new inhaler was ordered on 6/25/2026. The updated sticker for R89's insulin pen was added on 6/28/2026. All residents have the potential to be affected by this deficient practice. To prevent reoccurrence, all medication cabinets were audited on 7/2/2026 to ensure that medications were stored and labeled properly. To ensure deficient practice will not recur, education on policy Medication: Change of Direction Stickers will be completed with nursing staff by 7/10/2026. DNS or designee will initiate a monthly review of medication rooms and medication cabinets to review proper storage and labeling of medications. To ensure compliance is maintained, random audits of medication cabinets by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to ensure medications are labeled/stored properly. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0761 SS = E	Continued from page 25 label to identify a change in orders but acknowledged there was no label in place. Upon review of the orders, it was noted the orders directed staff to give quetiapine fumarate 25 mg ½ tablet (12.5 mg) by mouth one time a day for depression at 4:00 p.m. and 25 mg by mouth one time a day for depression at 8:00 p.m. On 6/4/26 at 1:30 p.m., a review of the medication label and the prescription label was completed with the clinical manager (CM)-A. The label directed staff to administer ½ tablet (12.5 mg) by mouth once daily. Give one tablet (25 mg) at bedtime. CM-A acknowledged the label lacked indication regarding spacing of doses. CM-A stated there were stickers available to place on label to direct staff to electronic medical record. On 6/3/26 at 7:47 a.m., registered nurse (RN)-B provided R89 with the inhaler, Anoro Elipta, for one puff inhalation. The inhaler was noted to be in a plastic tray, and lacked any labeling to include resident name, medication date of dispensing, date of expiration, or directions for use. The inhaler was dated as opened 4/29/26. Additionally, resident was administered the following doses of insulin: Lantus Insulin (Insulin Glargine Subcutaneous Solution 100 mg/ml) 38 units sub q (within the upper level of flesh, but not into the muscle) however the label directed staff to administer 40 units sub q. Novolog Insulin Aspart Injection 100 unit/ml 11 units, however, the label directed staff to administer nine units of insulin sub q. RN-B stated the insulin labels should have been updated by pharmacy to reflect the current doses ordered, or a sticker should have been placed on the insulin pens to reflect there was a change in orders and to refer to the EMR. RN-B stated the inhaler should remain in the original packaging until supply was depleted. On 6/4/26 at 7:58 a.m., director of nursing (DON) stated all medications should be labeled with the resident's name, name of medication, date dispensed, med dispensed, date of expiration, and directions for use. DON stated the labels on the medication card should match the instructions on the MAR. If there were changes to the orders, there were stickers which would be placed which identify	F0761		07/10/2026

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F0761 SS = E	Continued from page 26 directions were changed and direct staff to refer to EMR. The facility policy, Medications: Administration Including Scheduling and Medication- R/S, LTC, date reviewed/revised 3/30/26, identified with medication pass, the staff were directed to read the label on the medication container and compare with the MAR when removing the container from the supply drawer. The policy lacked direction as to what to do if there were a discrepancy between the label and the prescription label.	F0761		07/10/2026
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	F550 (S/S = D): Resident Rights/Exercise of Rights R83 had nail care performed during the survey and again on 7/1/2026. All residents have the potential to be affected by this deficient practice. To prevent reoccurrence, all residents were reviewed to ensure nails were clean and trimmed to each resident's preference on 7/2/2026. To ensure deficient practice will not recur, education on policy Nail Care was completed with all staff by 7/10/2026. Facility will initiate Angel Rounding utilizing leadership in resident care areas to assess resident care needs being met. Nail care will be included in this Angel Round review. To ensure compliance is maintained, random audits of nail care by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to nails are clean and trimmed to each resident's preference. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0550 SS = D	Continued from page 27 §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 resident grooming needs were met for 1 of 1 resident (R83) in the sample reviewed for nail care. Finds include: R83's Admission Record (Face Page - print date of 6/4/26), documented the following diagnoses: Muscle weakness, disorientation, atrial fibrillation and essential hypertension. R83's Comprehensive Minimum Data Set (MDS) dated 3/19/26, assessed resident to be moderately cognitively impaired and required set-up to maximal assist with activities of daily living (ADLs). R83's Care Area Assessment for ADLs (CAA) dated 3/30/26, documented resident's "limiting factors" for the need of ADL assistance being causes for being dependent were "physical limitations such as weakness, limited range of motion, poor coordination, poor balance, visual impairment or pain". During observation and screening on 6/01/26 at 3:26 p.m., R83 had very long fingernails on all 10 fingers, which looked to be 1/4 inch and longer in length. R83 stated he was unable to cut them himself and stated he wished them to be trimmed. During daily observation from 6/1/26 though 6/4/26, R83 continued to have long fingernails. A review of R83's electronic medical record, under the section of "Tasks", it was documented R83 received weekly baths on Wednesdays. In review of R83's car plan (last revised 3/21/26), documented resident's dependence on staff, including the assist of one staff person during bathing task. On the morning of Thursday 6/4/26 (the day after resident's scheduled shower day) at 9:20 a.m., R83 was sitting at the central dining room area table feeding himself breakfast. R83's fingernails were long and uncut. R83 stated he received his shower last evening. No one offered to trim / cut his fingernails.During an interview on 6/4/26 at 9:46 a.m., nursing assistants (NA)-A and NA-B reviewed the electronic medical record task section and verified R83 received his shower the previous day at approximately 4:22 p.m. Both NA-A and NA-B stated residents should have their nails trimmed / cut with their weekly showers / baths. However, both NAs stated the NAs were not to cut fingernails but rather only the nurses. Both NA-A and NA-B stated they were only allowed to use emery boards and use fingernail polish on	F0550		07/10/2026

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F0550 SS = D	Continued from page 28 residents. In an observation and interview on 6/04/2026 at 9:55 a.m., registered nurse (RN)-A verified R83's nails should have been trimmed / cut yesterday with his shower. RN-A stated the NAs were allowed to trim / cut resident nails, as long as they were not diabetic. RN-A estimated 883's fingernails were all at least 1/4 inch in length. RN-A asked R83 if he wished his failed to be cut, with residents stating "yes". During a further observation and interview on 6/4/26 at 10:04 a.m., registered nurse care manager (CM)-A stated resident fingernails should be trimmed / cut weekly with baths / showers. CM-A further stated the NAs were to complete this task for residents noted to have long nails, unless they were diabetic. The NAs should inform the nurse of a diabetic needing nail care. When CM-A asked R83 if he wanted his nails cut, R83 responded "yes". During a final interview on 6/4/2026 at 12:50 p.m., the director of nursing (DON) stated it was the facility's expectation, resident would have their nails trimmed / cut with their weekly bath / shower if it was needed and/or the resident requested. If a resident refused nail care, staff should report the refusal to the nurse. DON stated all NAs have the ability to perform nailcare except for diabetic residents. In review of the facility's skills checklist), entitled: Nail Care Clinical Skill Checklist (undated), did not indicate when nails should be trimmed / cut but rather only the following: "[certified nursing assistants] check with care plan prior to procedure. Licensed nurses see physician orders. [certified nursing assistants] are not to do nail care on residents with diabetic or circulatory problems." The policy went on to indicate the skills required by the facility for staff to perform nail care, what to observed for and what to report to the nurse. In review of the facility's policy entitled: Nail Care (last revised 4/2/26) further clarified which resident the NAs (not diabetic or residents receiving anticoagulants) were able to do, supplies need and the process in performing nail care.	F0550		07/10/2026

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F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a resident and/or resident representative was informed of and participated in treatment decisions regarding psychotropic medications, including failure to obtain informed consent prior to the initiation of a psychotropic medication for 1 of 5 residents (R41) reviewed for psychotropic medication use. Findings include: R41's quarterly Minimum Data Set (MDS) dated 5/26/26, identified R41 had severe cognitive impairment and required assistance with activities of daily living (ADL's). R41's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by a physical injury), Alzheimer's disease (a progressive brain disorder affecting memory and thinking abilities), stroke (damage to the brain caused by interrupted blood flow), and non-Alzheimer's dementia (a decline in memory and cognitive function not caused by Alzheimer's disease). The MDS further indicated R41 had experienced two or more falls since admission. R41's physician orders dated 4/7/26, identified an order for risperidone, a psychotropic medication, which had been initiated on 1/29/26, when R41 was	F0552	F552 (S/S = D): Right to be Informed/Make Treatment Decisions Consent for psychotropic medication for R41 was received on 6/3/26. All residents that have an order for psychotropic medications have the potential to be affected by this deficient practice. To prevent reoccurrence, all residents were reviewed to ensure consent was obtained for all current psychotropic medications on 6/24/26. To ensure deficient practice will not recur, education on policy Psychotropic Medication was completed. Facility will follow policy and procedure obtaining consent for psychotropic mediations prior to initiation of medication. DNS or designee will initiate a review during weekly IDT meetings ensuring resident informed consent is obtained for psychotropic medication administration. To ensure compliance is maintained, random audits of newly ordered psychotropic medications by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to ensure consents were received prior to the initiation of a psychotropic medication. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0552 SS = D	Continued from page 30 admitted to the facility. Review of R41's electronic medical record (EMR) failed to identify documentation that informed consent for the psychotropic medication had been obtained from the resident and/or resident representative prior to the medication being initiated. Further review identified the consent had been obtained after the medication was started. During an interview on 6/4/26, at 12:26 p.m., RN Case Manager (CM)-C stated psychotropic medication consents were obtained upon admission and reviewed with the resident and/or family member. CM-C reviewed R41's EMR and stated she was unable to locate the consent in the EMR, so she contacted the family on 6/2/26 and obtained verbal consent over the phone. CM-C stated the consent form was important to ensure the resident and/or family agreed with the medications being administered and understood the associated risks and benefits of the medication. During an interview on 6/4/26 at 12:59 p.m., the director of nursing (DON) stated consent should have been obtained when the medication order was received, either upon admission if the resident was admitted on the medication or when a new psychotropic medication was initiated. The DON stated the consent should have been signed by the resident or the resident's family member prior to administration of the medication. Review of the facility's Psychotropic Medications Policy, reviewed/revised 12/09/2025, identified residents and/or their family or legal representative were to be notified when psychotropic medications were initiated or when residents were admitted on psychotropic medications. The policy further identified the Permission for Use of Psychotropic Medications (GSS #478) consent form was required to be completed and signed for the use of psychotropic medications.	F0552		07/10/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F0584	F584 (S/S = D): Safe/Clean/Comfortable/Homelike Environment A new assistive device was ordered on 6/4/2026 for R40 and received on 6/5/2026. All residents utilizing Broda Wheel Chairs have the potential to be affected. To prevent reoccurrence, all residents with Broda Wheel Chairs were reviewed to ensure device was in proper condition including	07/10/2026

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F0584 SS = D	Continued from page 31 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to maintain a broda chair (a specialized brand of wheelchair and positioning recliner designed for individuals with limited mobility who require long-term, comfortable sitting) in good repair for 1 of 1 resident (R40) reviewed who utilized a broda chair. Findings include: F40's quarterly Minimum Data Set (MDS) dated 5/11/26, indicated R40 had moderate cognitive impairment and was dependent on staff for activities	F0584	Continued from page 31 cleanliness, free from rips or cracks. Any concerns were addressed and replaced as needed. To ensure deficient practice will not recur, education on policy Resident Environment by 7/10/2026. Additionally, education on facility process of completing and submitting work orders was completed by 7/10/2026. Facility will initiate a new process of reviewing equipment needs and potential repairs during quarterly care plan meetings and as needed. To ensure compliance is maintained, random audits of assistive devices by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to ensure devices are in clean and proper working order. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0584 SS = D	Continued from page 32 of daily living (ADLs). R40's diagnoses included anemia, dementia, Huntington's disease, anxiety, depression and bipolar disorder. On 6/3/26 at 3:13 p.m. R40's broda chair was observed with four cracks on head rest cushion, the cracks were vertical on the cushion about six inches in length with the inner foam visible in the cracks. Cushioning on right side of R40's head was observed to have several cracks of varying length with inner foam visible in the cracks. Cushioning on left side of R40's head was observed to have an area of about eight inches by 6 inches of cracks with a diagonal jagged crack about seven inches in length with an area below about 6 inches by five inches of cracks, foam was visible in all cracked areas. The upper corners of the left side cushion with stuffing and foam observed sticking out. Follow up observation on 6/4/26 at 11:22 a.m. indicated R40 continued to be placed in the broda chair with cracked cushions with inner foam and stuffing visible. When interviewed on 6/4/26 at 11:28 a.m. certified nursing assistant (CNA)-C stated when equipment was broken or in poor repair, they were to complete a maintenance work order or inform hospice if the resident was on hospice for the equipment to be repaired or replaced. CNA-C stated were not aware R40's broda had cracked cushions When interviewed on 6/4/26 at 11:31 a.m. registered nurse (RN)-C stated R40 wore a helmet that had probably caused cracks in the cushions of the broda chair and due to R40 being on hospice they would have to be notified the broda chair cushions required repair or replacement. RN-C stated they were not aware if hospice was informed of the broda chair condition. When interviewed on 6/4/26 at 11:40 AM clinical care manager (CM)-B stated they had noticed several chairs that needed repair or replacement but had not yet informed hospice of the need. CM-B stated the concern with cracked cushions was infection control and the cushions could not be cleaned appropriately. When interviewed on 6/4/26 at 12:53 p.m. director of nursing (DON) stated the expectation was for equipment to remain in good repair, maintenance	F0584		07/10/2026

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F0584 SS = D	Continued from page 33 requests or update to hospice was expected to be completed in a timely manner to ensure cleanliness and infection control was maintained. Facility policy regarding resident equipment was requested, however, none was provided.	F0584		07/10/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F0628	F628 (S/S = D): Discharge Process R100 was discharged at time of survey. All residents requiring transfer or discharge have the potential to be affected. To prevent reoccurrence, residents discharged from the center in the last 90 days were reviewed to ensure written notice of transfer was provided to the resident and/or resident representative prior to transfer by 7/2/2026. To ensure deficient practice will not recur, education on policy Discharge and Transfers was completed with Social Services staff on 6/30/2026. Facility will follow policy and procedure as it relates to involuntary transfers/discharges and proper notifications. To ensure compliance is maintained, random audits of discharged residents by the Social Services Manager or designee weekly x 4 and monthly x 3 to ensure written notice of transfer was provided to the resident and/or resident representative prior to transfer. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0628 SS = D	Continued from page 34 (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an	F0628		07/10/2026

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F0628 SS = D	Continued from page 35 appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F0628		07/10/2026

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F0628 SS = D	Continued from page 36 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide and document written notice of an involuntary transfer/discharge to a resident and/or resident representative prior to transfer to another facility, for 1 of 1 resident (R100) reviewed for transfer and discharge requirements. Findings include:	F0628		07/10/2026

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F0628 SS = D	Continued from page 37 R100's clinical record identified R100 was transferred from the facility to a sister facility on 8/22/25. Review of R100's electronic health record (EHR) failed to identify documentation that the resident and/or resident representative received written notice of the involuntary transfer/discharge prior to the transfer. The record failed to identify documentation of a Notice of Involuntary Discharge (NOID), notification of appeal rights, evidence of notification to the resident and/or resident representative, documentation of attempted contact with resident and/or resident representative, or notification to the Ombudsman program regarding the discharge. During an interview on 6/4/26 at 11:01 a.m., Social Worker (SW)-A stated when residents were discharged, the facility typically issued a Notice of Medicare Non-Coverage (NOMNC), discussed appeal rights, reviewed discharge information with the resident, coordinated communication with outside providers, and arranged transportation if needed. SW-A stated that for facility-initiated discharges, options were reviewed with the resident and discharge planning was discussed. SW-A stated she was aware there had been months of discussions involving the Ombudsman program and regional staff regarding R100 and issues related to unpaid bills. SW-A further stated she knew a great deal of information leading up to the discharge but did not know all of the events surrounding the discharge. SW-A confirmed there was no documentation regarding attempts to contact the resident's daughter or documentation related to discharge planning. SW-A stated the Administrator ultimately took over management of the discharge process. During an interview on 6/4/26 at 11:26 a.m., the Administrator stated R100 was transferred to the facility's sister facility on 8/22/25 and the resident's long-term care needs continued to be met. The Administrator stated notice of the discharge had been relayed to the resident; however, she could not provide documentation or evidence supporting that notification. The Administrator further acknowledged there were missing pieces in the discharge record and confirmed she could not locate documentation of the required discharge notice. During an interview on 6/4/26 at 11:35 a.m., the Ombudsman stated she had discussed R100's discharge with the facility on 9/18/25 and informed facility staff that the required discharge process had	F0628		07/10/2026

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F0628 SS = D	Continued from page 38 not been followed. The Ombudsman stated she was unable to find evidence that a Notice of Involuntary Discharge had been issued, evidence that the resident and/or resident representative had been notified, or evidence of attempts to contact the resident representative regarding the discharge. The Ombudsman further stated there was no documentation supporting these actions and confirmed the Office of Ombudsman for Long-Term Care had not received notification of the discharge. The facility's "Discharge and Transfer – Rehab/Skilled, Therapy & Rehab" policy, reviewed 1/15/26, required that before a resident was transferred or discharged, the facility notify the resident and resident representative in writing of the transfer/discharge and the reason for the move using the Notification of Transfer or Discharge (GSS #223A) or other state-required form. The policy further required the facility provide information regarding appeal rights and assistance with obtaining and completing an appeal form. A copy of the transfer/discharge notice was required to be sent to the Office of the State Long-Term Care Ombudsman. For transfers related to non-payment, the policy required at least 30 days' advance notice before the transfer or discharge occurred. The policy also required the facility to provide and document sufficient preparation, orientation, and discharge planning to ensure a safe and orderly transfer or discharge.	F0628		07/10/2026
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to timely complete a comprehensive assessment after a significant change in status, including failure to complete a Significant Change in Status Assessment (SCSA) following discharge from	F0637	F637 (S/S = D): Comprehensive Assessment After Significant Chg Significant Change in Status Assessment (SCSA) was completed for R111 on 7/2/2026. All residents that are admitted or discharged from hospice have the potential to be affected by deficient practice. All residents admitted to or discharged from hospice in the last 90 days were reviewed on 7/2/2026 to ensure a SCSA was completed within the required timeframe. Those not compliant were completed as appropriate. To ensure deficient practice will not recur, education on policy MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument) was completed with nurse leaders responsible for MDS assessments by 7/10/2026. DNS or designee will initiate a review during weekly IDT meetings ensuring residents who admit or discharge from Hospice Services have a	07/10/2026

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F0637 SS = D	Continued from page 39 hospice services, for 1 of 1 resident (R111) reviewed for MDS assessment requirements. The Resident Assessment Instrument (RAI) User's Manual identified enrollment in hospice services and discharge from hospice services as events that may constitute a significant change in status requiring completion of a Significant Change in Status Assessment. Findings include: R111's most recent Minimum Data Set (MDS) assessment identified diagnoses which included chronic obstructive pulmonary disease (COPD; a chronic lung disease that makes breathing difficult) and chronic respiratory failure (a condition in which the lungs are unable to adequately exchange oxygen and carbon dioxide). The MDS further identified R111 received hospice services. R111's clinical record identified hospice services were discontinued on 5/11/26. Review of R111's electronic health record (EHR) on 6/4/26 identified documentation continued to reflect R111 was receiving hospice services, including on the resident profile and care plan, despite hospice services having ended on 5/11/26. During interview on 6/4/26 at 9:27 a.m., nursing assistant (NA)-E stated R111 was on hospice services and confirmed care plans were primarily updated by the nurse manager. During interview on 6/4/26 at 9:33 a.m., licensed practical nurse (LPN)-B stated R111 had been on hospice services and had graduated from hospice. LPN-B stated the facility had held a care conference regarding the possibility of restarting hospice services; however, R111 did not meet hospice criteria. During interview on 6/4/26 at 12:32 p.m., registered nurse case manager (CM)-C stated R111 was discharged from hospice after a hospitalization on 5/10/26 and was scheduled to be discharged from hospice on 5/11/26. CM-C reviewed the EHR and confirmed it continued to identify R111 as receiving hospice services. CM-C stated the record should have been updated to accurately reflect the resident's current status. CM-C further stated she completed the Significant Change in Status Assessment on 6/3/26 after the surveyor requested information regarding the resident's hospice discharge.	F0637	Continued from page 39 Significant Change in Status Assessment (SCSA) completed. To ensure compliance is maintained, random audits of residents admitted to or discharged from hospice by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to ensure a SCSA was completed within the required timeframe. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0637 SS = D	Continued from page 40 During interview on 6/4/26 at 12:59 p.m., Director of Nursing (DON) stated hospice discharges generated notifications to administration staff and required updates to the resident's care plan and clinical record. The DON stated documentation was typically received from the hospice agency at discharge and confirmed a Significant Change in Status Assessment should have been completed following the hospice discharge. The DON stated it was important for the record to accurately reflect the resident's current status and care needs in real time. During interview on 6/4/26 at 1:29 p.m., MDS nurse (RN)-E reviewed the resident's assessment history and stated the Significant Change in Status Assessment was completed on 6/3/26. Review of the facility's MDS assessment history confirmed a Significant Change in Status Assessment was not completed until 6/3/26, approximately three weeks after R111's discharge from hospice services on 5/11/26. Review of the facility's MDS 3.0 (Minimum Data Set) RAI policy, revised 10/27/25, identified when a significant change in a resident's status was identified, staff were to notify the social worker, RN coordinator, or designated employee so a timeline could be established and communicated to interdisciplinary team members. The policy further required documentation of the significant change in the PN-MDS, notification of the interdisciplinary team through the MDS/Care Plan Notification process, and completion of the Significant Change MDS in accordance with the Resident Assessment Instrument (RAI) Manual requirements and timelines.	F0637		07/10/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure professional standards of practice were followed during administration of crushed medications for 1 of 2	F0658	F658 (S/S = D): Services Provided Meet Professional Standards A physician’s order to crush medications for R68 was obtained on 6/3/26. All residents deemed appropriate for crushed meds have the potential to be affected by this deficient practice. The prevent reoccurrence, those deemed appropriate were verified to have a physician’s order to crush medications on 7/2/2026. To ensure deficient practice will not recur, education on policy Medications: Crushing was completed with	07/10/2026

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F0658 SS = D	Continued from page 41 residents (R68) observed during medication administration. Findings include: R68's Annual Minimum Data Set (MDS) dated 1/6/26, identified R68 as exhibiting severe cognitive deficit and was identified as requiring assist with all aspects of activities of daily living (ADLs-dressing, grooming, bathing, and toileting). R6's medical diagnoses included aphasia (difficulty with speaking), anemia (a low blood count of red blood cells or hemoglobin), hypertension (high blood pressure) and non-Alzheimer's dementia (a condition which may cause alteration in thoughts, cognition, and behavior). R68's Admission Profile printed 6/4/26, indicated R68 had diagnoses of generalized muscle weakness. R68's Care Plan revised 2/23/26, indicated R68 had limited physical mobility related to history of a stroke with right side weakness and received antiplatelet therapy. R68's care plan identified an order in place for a texture modified diet. The care plan lacked indication prior to 6/3/26. R28 was okay to have crushed meds. During a medication observation on 6/3/26 at 7:31 a.m. R68 was given the following medications were crushed together and mixed with applesauce and given orally: Clopidgrel 75 mg one tablet; Senexon S 500 mg/8.6 mg one tablet; and Amlodipine 10 mg one tablet. Registered nurse (RN)-B stated R68's medications were crushed and mixed together with applesauce for R68. RN-B stated this was able to be completed as it was ordered by the provider. On 6/3/26 at approximately 10:00 a.m., DON stated all medications which required crushing were to have an order in place. DON stated this was important to assure medications were able to be crushed based on timed release status, protective coating, etc. DON stated she was unaware if there were orders in place for R68, however, affirmed medications were not to be crushed without provider orders. R68's progress notes were reviewed and identified on 6/3/26 at 12:46 p.m., an order was received from the provider that it was "okay to crush meds" due to history of stroke and seizure. A review of R68's cumulative orders lacked indication of authorization to crush medications prior to 6/3/26.	F0658	Continued from page 41 nursing staff by 7/10/2026. DNS or designee will initiate a review during clinical leadership meetings of new admissions ensuring to obtain orders as appropriate for residents who require medications to be crushed. To ensure compliance is maintained, DNS or designee will audit 10% of resident population for proper Medication Administration to ensure orders to crush medication are used appropriately weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0658 SS = D	Continued from page 42 The facility policy, Medications: Crushing-AL, R/S, LTC, date reviewed/revised 1/29/26 identified the attending provider must be aware of the need to crush medications so that the appropriate form of the medication can be ordered. The policy further states best practice would be to separately crush each medication and separately administer each medication with food.	F0658		07/10/2026
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 record review, the facility failed to ensure physician-ordered parameters were monitored prior to administration of an antihypertensive medication, including failure to obtain blood pressure readings to determine whether a PRN dose of metoprolol was indicated, for 1 of 1 resident (R91) reviewed for medication administration parameters. Findings include: R91's quarterly Minimum Data Set (MDS) dated 3/23/26 identified R91 had severe cognitive impairment and required assistance with activities of daily living (ADL)'s. R91's diagnoses included schizophrenia (a chronic mental health disorder that affects a person's ability to think clearly, perceive reality, manage emotions, and interact with others). The MDS further identified R91 received antipsychotic medications. R91's physician orders identified an order for Metoprolol Tartrate 12.5 mg (milligram) by mouth every 24 hours as needed for blood pressure greater than 150 related to paranoid schizophrenia. The order was initiated on 3/30/26. R91's electronic health record (EHR) identified the PRN metoprolol order remained active. Review of the	F0684	F684 (S/S = D): Quality of Care On 6/18/26, R91's physician was notified and provided new orders to discontinue the PRN metoprolol. All residents with PRN Blood Pressure medications have the potential to be affected by deficient practice. DNS or designee will review all residents with PRN Blood Pressure medication orders to ensure proper blood pressure monitoring is occurring on 7/2/2026. Will consult with MD as needed with any findings. To ensure deficient practice will not recur, education on policy Medication: Documentation was completed with nursing staff on by 7/10/2026. The DNS or designee will initiate a separate nursing order for residents with PRN blood pressure medication orders. This order will ensure appropriate blood pressure monitoring and alert nursing staff when PRN medication is available for administration according to established parameters. To ensure compliance is maintained, the DNS or designee will audit 10% of all residents with PRN Blood Pressure medications to ensure proper Blood Pressure monitoring is occurring weekly x 4 and monthly x 3 to ensure blood pressure monitoring was completed. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0684 SS = D	Continued from page 43 EHR identified the facility obtained R91's blood pressure on a weekly basis; however, the record failed to identify blood pressure monitoring was completed to determine whether R91's blood pressure exceeded the ordered parameter of greater than 150 and whether administration of the PRN medication was indicated. The record further failed to identify documentation the facility evaluated the ongoing need for the medication or whether the ordered blood pressure parameter was ever met. During an interview on 6/4/26 at 9:41 a.m., licensed practical nurse (LPN)-B reviewed R91's physician orders and stated R91 had an order for PRN metoprolol. LPN-B stated he believed the medication was intended for symptoms that occurred during aggressive episodes. During an interview on 6/4/26 at 12:32 p.m., registered nurse case manager (CM)-C stated R91's family did not want R91 routinely receiving metoprolol and a decision had been made during a care conference to change the medication to PRN use. CM-C reviewed the physician order and stated the facility should have obtained clarification from the provider regarding blood pressure monitoring parameters. CM-C further stated the order should have included instructions regarding how often blood pressure readings were to be obtained and acknowledged staff should have been monitoring R91's blood pressure to determine whether the medication was indicated. During an interview on 6/4/26 at 12:59 p.m., director of nursing (DON) reviewed the physician order and stated R91's blood pressure should have been monitored and there should have been an order identifying how frequently blood pressure readings were to be obtained. DON stated staff should have followed up with the physician for clarification regarding blood pressure monitoring expectations related to the PRN metoprolol order. A facility policy regarding monitoring and administration of PRN antihypertensive medications, including blood pressure monitoring expectations and physician order clarification requirements, was requested and was not received.	F0684		07/10/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F0883	F883 (S/S = D): Influenza and Pneumococcal Immunizations The resident representative for R29 was offered missing vaccinations on 6/23/2026.	07/10/2026

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F0883 SS = D	Continued from page 44 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F0883	Continued from page 44 All residents have potential to be affected by this deficient practice. To prevent reoccurrence, all residents were reviewed on 6/30/2026 to ensure the immunizations had been offered as appropriately. Additionally, any residents that refused vaccinations were reviewed to ensure education on the risks/benefits was documented. To ensure deficient practice will not recur, education on policy Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other was completed with nursing staff by 7/10/2026. DNS or designee will initiate a review during clinical leadership meetings of new admissions ensuring vaccines have been offered appropriately after admitting to the facility. To ensure compliance is maintained, random audits of new admissions by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to ensure the immunization tab was updated timely. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0883 SS = D	Continued from page 45 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: During interview and record review, the facility failed to ensure all residents were offered and up to date on immunizations for 1 of 5 residents (R29) reviewed for immunizations. Findings include: Information on the CDC website: Pneumococcal Disease link, outlined on the CDC website and dated 2/25/26, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This site identified recommendations for those who had never been vaccinated for pneumococcal disease, as well as those who had started the pneumococcal process. Additionally, the link to Influenza (Flu) site dated 9/18/25, identified everyone six months and older should get a flu vaccine every season with rare exceptions. R29's admission minimum data set (MDS) dated 5/14/26, included an admission date of 4/29/26, and R29 was identified as being 87 years of age. R29's medical diagnoses included coronary artery disease (the narrowing of arteries which decreases blood flow to the heart), hypertension (high blood pressure), and non-Alzheimer's dementia (loss of memory and other intellectual functions, affecting the ability to perform activities of daily living ADL's). R29's electronic medical record (EMR) lacked a review of current immunizations, including those which would have been received prior to admission. This review would have included the current status on pneumococcal immunizations, as well as influenza vaccinations. Additionally, a review was completed to identify if vaccinations had been declined as evidenced by presence of a vaccine consent marked "refused". The EMR was lacking any consent for vaccination reviewed with R29 or his responsible party. During interview on 6/3/26 at 2:07 p.m., infection preventionist (IP) stated every resident's immunization status was reviewed by the admission nurse within the first 24 hours following admission. IP stated resident's immunization status was then verified via MIIC (Minnesota Immunization	F0883		07/10/2026

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F0883 SS = D	Continued from page 46 Information Connection-a web-based system to allowing tracking of immunizations given) by IP to assure the vaccine had not been previously given. Once verified, the necessary immunizations were offered. Upon review of R29's immunization tab in the EMR, IP stated R29's immunization status had not been reviewed, and the record lacked a vaccination history, or offering of vaccinations. IP stated this should have been completed at the time of admission. The facility policy, Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, Covid-19, reviewed/revised 11/8/25 identified the purpose of the immunization program was to promote the health and safety of residents/patients, employees, and visitors through protection against vaccine-preventable diseases. The policy identified Skilled nursing facilities (SNFs) are federally required to provide education and offer any influenza, COVID-19, or pneumococcal vaccine a resident is eligible to receive. The process identified resident were to be screened for eligibility and any contraindications to a vaccine following CDC recommendations. The SNF was then to provide the resident and/or their legal medical decision-maker with a vaccine information sheet to educate on the risks and benefits of a vaccine the resident is eligible to receive, and document education provided in the medical record. Once the education was provided, staff were then to obtain consent or declination for the vaccine and document in the medical record. The facility was then to follow up with the provider for orders for vaccination and proceed with vaccination, monitoring, and documentation.	F0883		07/10/2026
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects	F0887	F887 (S/S = D): COVID-19 Immunization The resident representative for R29 was offered the missing vaccinations on 6/23/2026. All residents have potential to be affected by this deficient practice. To prevent reoccurrence, all residents were reviewed on 6/30/2026 to ensure each resident had immunizations offered as appropriately. Additionally, any residents that refused vaccinations were reviewed to ensure education on the risks/benefits was documented. To ensure deficient practice will not recur, education on policy Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other was	07/10/2026

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F0887 SS = D	Continued from page 47 associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the facility failed to ensure COVID-19 immunization was offered and/or administered in accordance with current	F0887	Continued from page 47 completed with nursing staff by 7/10/2026. DNS or designee will initiate a review during clinical leadership meetings of new admissions ensuring vaccines have been offered appropriately after admitting to the facility. To ensure compliance is maintained, random audits of new admissions by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to ensure the immunization tab was updated timely. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0887 SS = D	Continued from page 48 standard of practice for 1 of 5 residents (R29) reviewed for immunizations. Findings include: A Centers for Disease Control and Prevention (CDC) COVID-19 Vaccination Guidance updated 11/4/25, indicated individuals should receive recommended COVID-19 vaccinations, including booster doses, when eligible, unless medically contraindicated or refused. Long-term care facilities were responsible for assessing vaccination status and ensuring residents were offered recommended vaccines. R29's admission minimum data set (MDS) dated 5/14/26, included an admission date of 4/29/26, and R29 was identified as being 87 years of age. R29's medical diagnoses included coronary artery disease (the narrowing of arteries which decreases blood flow to the heart), hypertension (high blood pressure), and non-Alzheimer's dementia (loss of memory and other intellectual functions, affecting the ability to perform activities of daily living ADL's). R29's electronic medical record (EMR) lacked a review of current immunizations, including those which would have been received prior to admission. This review would have included the current status on Covid-19 vaccinations. Additionally, a review was completed to identify if vaccinations had been declined as evidenced by presence of a vaccine consent marked "refused". The EMR lacked any consent for vaccination reviewed with R29 or his responsible party. During interview on 6/3/26 at 2:07 p.m., infection preventionist (IP) stated every resident's immunization status was reviewed by the admission nurse within the first 24 hours following admission. IP stated resident's immunization status was then verified via MIIC (Minnesota Immunization Information Connection-a web-based system to allowing tracking of immunizations given) by IP to assure the vaccine had not been previously given. Once verified, the necessary immunizations were offered. Upon review of R29's immunization tab in the EMR, IP stated R29's immunization status had not been reviewed, and the record lacked a vaccination history, or offering of vaccinations. IP stated this should have been completed at the time of admission. The facility policy, Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, Covid-19, reviewed/revised 11/8/25 identified the purpose of	F0887		07/10/2026

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F0887 SS = D	Continued from page 49 the immunization program was to promote the health and safety of residents/patients, employees, and visitors through protection against vaccine-preventable diseases. The policy identified Skilled nursing facilities (SNFs) are federally required to provide education and offer any influenza, COVID-19, or pneumococcal vaccine a resident is eligible to receive. The process identified resident were to be screened for eligibility and any contraindications to a vaccine following CDC recommendations. The SNF was then to provide the resident and/or their legal medical decision-maker with a vaccine information sheet to educate on the risks and benefits of a vaccine the resident is eligible to receive, and document education provided in the medical record. Once the education was provided, staff were then to obtain consent or declination for the vaccine and document in the medical record. The facility was then to follow up with the provider for orders for vaccination and proceed with vaccination, monitoring, and documentation.	F0887		07/10/2026
F0574 SS = C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and	F0574	F574 (S/S = C): Required Notices and Contact Information The required posting was obtained and displayed on 6/2/2026. All residents have the potential to be affected by this deficient practice. To ensure deficient practice will not recur, education on policy Posting Information, Social Services-Rehab/Skilled was completed with social services staff on 6/30/2026. To ensure compliance is maintained, random audits of the required postings by the Administrator or designee weekly x 4 and monthly x 3 to ensure all required postings are displayed. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

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F0574 SS = C	Continued from page 50 (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was displayed for residents, visitors, and staff to review. This had the potential to affect all 88 residents currently residing in the facility, as well as all staff and visitors. Findings include: On 6/2/26 at 10:13 a.m., it was observed that RBOR poster was displayed in a locked glass case right off the main entrance, near	F0574		07/10/2026

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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
F0574 SS = C	Continued from page 51 the elevators, which lacked the date of print. A facility combined RBOR was posted next to the entrance of the therapy room, just off the main lobby, which was dated 11/16. On 6/2/26 at 2:15 p.m. the administrator stated she was unaware any changes made to the RBOR form and was unaware of the need to obtain and post the updated version. The facility policy, Posting Information, Social Services-Rehab/Skilled, revised 12/23/25, identified all residents residing in the facility had the right to be aware of a certain location where information concerning it's [the facility] operation, as well as their [the residents] right of appeal and advocacy. The policy indicated it was the responsibility of the location [facility] to keep this information posted in a visible place, accessible to all residents, whether ambulatory or in a wheelchair, and to keep it updated at all times. A listing of the required information to be posted in this location included the Resident's Rights for Skilled Nursing Facilities.	F0574		07/10/2026
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and	F0577	F577 (S/S = C) Right to Survey Results/Advocate Agency Info The survey binder was updated on 6/2/2026. All residents have the potential to be affected by this deficient practice. To ensure deficient practice will not recur, education on policy Posting Information, Social Services-Rehab/Skilled was completed with social services staff on 6/30/2026. To ensure compliance is maintained, random audits of the survey binder by the Administrator or designee weekly x 4 and monthly x 3 to ensure survey results and plans of corrections are posted timely. Results will be brought to the QAPI committee for further recommendations. Compliance date 7/10/2026.	07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

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F0577 SS = C	Continued from page 52 accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all recent facility survey results were posted in an accessible location for residents, staff, and visitors. This had the potential to affect all 88 residents residing in the facility as well as staff and visitors. Findings include: On 6/2/26 at 10:13 a.m., a review was completed of the facility survey binder, located on a table on the side wall of the lobby. A review of the binder was completed to ensure all surveys from the last recertification, completed 2/14/25, and subsequent follow up surveys (including complaint investigations and their findings) were available for review. Upon review of the documentation, it was noted that the binder lacked information from the following complaint investigations surveys completed on 12/31/25, 4/2/26, 4/8/26 and 5/15/26.On 6/2/26 at 2:16 p.m. the administrator reviewed the survey binder and acknowledged the above listed survey results were lacking in the binder. Administrator stated the survey results in the binder were to reflect the survey results of the past three years. Administrator stated this was important, so the results were available for residents, visitors, and family members to review if they wished to do so. The facility policy, Posting Information, Social Services-Rehab/Skilled, revised 12/23/25, identified all residents residing in the facility had the right to be aware of certain location information concerning its [facility's] operation, as well as their [the residents] right of appeal and advocacy. The policy indicated it was the responsibility of the location to keep this information posted in a visible place, accessible to all residents, whether ambulatory or in a wheelchair, and to keep it updated at all times. A list of the required information to be posted included the most recent federal or state survey (CMS Form #2567) and, if applicable, plans of correction.	F0577		07/10/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 06/01/26 through 06/04/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed and found	20000		07/10/2026

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/04/2026**

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20000	Continued from page 1 to be Unsubstantiated: H5279616C (2992047). NO licensing orders were issued. H52792618C (2980235). NO licensing orders were issued. H52792619C (2980218). NO licensing orders were issued. H52792620C (2979001). NO licensing orders were issued. H52792621C (2710080). NO licensing orders were issued. H52792622C (2664767). NO licensing orders were issued. The following complaints were reviewed and found to be Substantiated: H5479623C (3009703). NO licensing orders were issued. H5279614C (3006755). NO licensing orders were issued. H52792617C (2981289). NO licensing orders were issued. H52792625C (2627017). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational	20000		07/10/2026

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20000	Continued from page 2 Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		07/10/2026
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to revise comprehensive care plans to reflect significant changes in resident status, conditions, preferences, and interventions, for 3 of 3 residents (R111, R7, and R75) reviewed for care plan revision. Further, the facility failed to update the care plan with specific interventions for 2 of 2 residents (R1 and R122) reviewed for privacy of care. Findings include: R111	20570	Corrected	07/10/2026

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20570	Continued from page 3 R111's discharge return anticipated MDS dated 5/15/26, identified R111 had moderate cognitive impairment and required assistance with ADLs. R111's diagnoses included cancer (a disease in which abnormal cells grow uncontrollably), septicemia (a serious bloodstream infection), and non-Alzheimer's dementia (a decline in memory and cognitive functioning not caused by Alzheimer's disease). The MDS further identified R111 was receiving hospice services. R111's EHR identified hospice services were discontinued on 5/11/26. R111's care plan printed of 6/2/26, identified a focus area which stated, "The resident has a terminal prognosis R/T prostate cancer E/B on Optage Hospice," with an initiation date of 12/9/25. However, the care plan continued to indicate R111 was receiving hospice services after hospice services were discontinued on 5/11/26 and failed to be revised to reflect the resident's discharge from hospice. R111's care plan printed 6/4/26, further identified "The resident requires Enhanced Barrier Precautions (EBP) R/T wound." R111's EHR identified the wound had healed and R111 remained on EBP due to the presence of a urinary catheter. The care plan failed to be revised to reflect the resident's current need for EBP precautions and continued to identify the healed wound as the basis for the intervention. R7 R7's comprehensive Minimum Data Set (MDS) dated 5/4/26 identified R7 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R7's diagnoses included diabetes mellitus (a chronic condition that affects how the body uses blood sugar) and cerebrovascular accident (CVA; damage to the brain caused by interrupted blood flow). The MDS further identified R7 received insulin, an anticoagulant, and an antidepressant. R7's care plan printed 6/2/26, identified a care plan focus titled, "The resident has respiratory infection: Influenza A," with an initiation date of 12/25/25. R7's electronic health record (EHR) failed to identify ongoing signs, symptoms, treatment, or diagnosis of Influenza A. The care plan continued to identify Influenza A as an active care plan focus despite resolution of the condition and failed to identify revision or discontinuation of the focus area.	20570		07/10/2026

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20570	Continued from page 4 R75 R75's comprehensive MDS dated 4/13/26, identified R75 had severe cognitive impairment and required assistance with ADLs. R75's diagnoses included non-Alzheimer's dementia (a decline in memory and cognitive functioning not caused by Alzheimer's disease) and post-traumatic stress disorder (PTSD; a mental health condition that can develop after experiencing or witnessing a traumatic event). The MDS further identified R75 displayed physical and verbal behavioral symptoms directed toward others, as well as other behavioral symptoms not directed toward others, one to three days during the assessment period. The MDS also identified wandering behavior one to three days during the assessment period. R75's care plan printed 6/2/26, identified dining preference interventions indicating the resident preferred to sit alone during mealtimes and liked to sit in the dining room by the television next to the window. R75's EHR further identified behavior management interventions had been implemented, including placement of a bookshelf sticker on the resident's door and installation of a door chime to alert staff when residents entered or exited the room. Review of the care plan failed to identify either intervention. Observation on 6/2/26 at 12:13 p.m. identified R75 exited his room and sat at a dining room table with another resident while waiting for lunch. A door chime sounded when the resident's room door opened. Observation on 6/2/26 at 12:20 p.m. identified R75 ate lunch with two other residents and engaged in conversation with them. Observation on 6/2/26 at 12:22 p.m. identified another resident sat at the table with R75, and R75 greeted the resident. Observation on 6/3/26 at 8:13 a.m. identified R75 exited his room for breakfast and a door chime sounded when the door opened. R75 then sat in the dining room with two other residents in the main dining room. During an interview on 6/4/26 at 9:27 a.m., nursing assistant (NA)-E stated R111 was on hospice and was on EBP precautions due to having a urinary	20570		07/10/2026

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20570	Continued from page 5 catheter. During an interview on 6/4/26 at 9:31 a.m., NA-D stated R75 was easily agitated and was protective of his personal space. NA-D stated a door chime alerted staff when the resident's door opened so staff could ensure other residents did not enter the room. NA-D further stated a bookshelf sticker had been placed on the resident's door approximately one month earlier. NA-D stated R75 initially sat in the small dining room when he was admitted to the facility but had been sitting in the main dining room with other residents for quite some time. NA-D also stated R7 had not been sick in "quite a while." During an interview on 6/4/26 at 9:33 a.m., licensed practical nurse (LPN)-B stated R111 had graduated from hospice services and the facility had discussed the possibility of restarting hospice services; however, R111 did not meet the criteria. LPN-B stated R111 was on EBP precautions due to a urinary catheter and had not had a wound for several months. R75 previously exhibited exit-seeking behaviors but had mellowed considerably and spent more time outside of his room. To address those behaviors, a door chime and bookshelf sticker had been implemented approximately one month earlier to alert staff if another resident wandered into R75's room. R7 had not had Influenza since the previous year. LPN-B stated care plans should be updated to reflect changes in resident conditions and interventions and could be updated by nursing staff, although the nurse manager completed most care plan revisions. During an interview on 6/4/26 at 12:32 p.m., registered nurse case manager (CM)-C stated R75 was territorial regarding his personal space and could be paranoid at times, although his behavior had improved. CM-C stated a bookshelf sticker and door chime had been implemented on 5/7/26 and had been effective interventions; however, neither intervention was included in the care plan. CM-C stated it was important for staff to be aware of the interventions and confirmed they should have been care planned. CM-C further confirmed R75 initially sat in the small dining room but currently sat in the main dining room with three other residents and stated the dining preference intervention should have been revised to reflect the resident's current	20570		07/10/2026

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20570	Continued from page 6 preference. R111 was discharged from hospice services on 5/11/26 following hospitalization. CM-C reviewed the EHR and confirmed hospice services continued to be identified in the record and on the care plan despite the hospice discharge. CM-C further confirmed R111 no longer had a wound and remained on EBP precautions due to a urinary catheter and stated the care plan should have been revised to accurately reflect the resident's hospice status and current reason for EBP precautions. R7 no longer had Influenza A and that the care plan continued to identify Influenza A as an active respiratory infection despite the diagnosis occurring in 2025. CM-C stated the care plan should have been revised to remove the resolved condition. During an interview on 6/4/26 at 12:59 p.m., director of nursing (DON)-A stated hospice discharge notifications should prompt review and revision of the care plan and that a significant change MDS should be completed following discharge from hospice services. DON-A stated care plans should be updated whenever a resident experienced a new diagnosis, condition, intervention, preference change, or other significant change in status. DON-A further stated care plans served as the primary communication tool for staff and should accurately reflect the resident's current needs, interventions, and preferences to ensure staff understood how to provide appropriate care. The facility's policy, Care Plan - R/S, LTC, Therapy & Rehab, revised 12/1/25, indicated each resident would have an individualized, person-centered comprehensive care plan that addressed the resident's medical, nursing, physical, functional, emotional, psychosocial, and educational needs. The policy indicated care plans would be based on assessments, the Resident Assessment Instrument (RAI), physician orders, and identified resident problems, needs, and concerns. The policy further indicated the comprehensive care plan would be modified to reflect the care currently required and provided to the resident. Care plans were to be reviewed at least quarterly and reviewed, evaluated, and updated whenever there was a significant change in the resident's condition. R1 R1’s significant change assessment of 3/24/26 indicated R1 had moderate cognitive impairment. The assessment identified R1 was able to communicate	20570		07/10/2026

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20570	Continued from page 7 his needs and wishes and was able to understand information relayed to him. R1 was identified as needing assistance with activities of daily living (ADL's-dressing, grooming, and bathing). R1's medical diagnoses included headaches, cardiorespiratory debility (lack of function related to heart and respiratory problems), heart failure, hypertension (high blood pressure), renal chronic kidney disease (alteration in kidney function related to removal of waste through the kidney), diabetes (alteration in the way the body processes sugar), CVA (cardiovascular accident-stroke), hemiplegia/hemiparesis (loss of use/mobility of one side of the body), and anxiety. R1's care plan from admission of 1/3/26 lacked indication of use of camera, rationale for use, and placement by family for monitoring and interaction with R1. A facility document, titled Electronic Monitoring Notification and Consent Form (GSS 686) dated 11/17, identified R1 would like camera placed on 3/15/26, and would include video and audio. The form was not signed by family member and staff member until 4/6/26. R1's progress notes of 4/6/26, identified staff had discussed "video surveillance in progress" and provided the GSS 686 for completion. At that time the document was reviewed and completed with signatures of both family member and staff. The progress notes reflected a sign was placed on door to indicate to staff/visitors electronic monitoring was in place. R122 R122's Admission Profile indicated admission on 4/2/26, medical diagnoses included: Wernicke's encephalopathy (neurological symptoms (impaired vision and confusion) caused by lesions of the central nervous systems after exhaustion of B-vitamin reserves, alcohol dependence (in remission), anemia (low red blood cells or hemoglobin) and osteoarthritis (inflammation of joints). R122's care plan initiated 4/2/26, and last revised 4/24/26, lacked indication of use of video camera with audio capability for resident, as well as rationale for use, and other interventions related to this (signage, staff awareness, interaction with family through audio).	20570		07/10/2026

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20570	Continued from page 8 A facility document, titled Electronic Monitoring Notification and Consent Form (GSS 686) dated 11/17, identified R122 would like camera placed on 4/6/26, and would include video and audio. The form was signed by family member and staff member on 4/6/26. R122's progress notes of 4/6/26, identified staff had discussed "video surveillance in progress" and provided the GSS 686 for completion. The note indicated staff member had left document for signature by family member. The documentation indicated once consent was signed, the camera was to be plugged in, and consent turned into the nurse's station. A copy of the signed consent was on file. A subsequent note of 4/10/26, indicated family was observing via camera and alerted staff of R122s need for help. During interview on 6/4/26 at 12:57 p.m. licensed social worker (LSW)-A, stated R1 had cameras found in his room without staff awareness. LSW-A stated family was contacted, a GSS-686 consent was completed, and the camera was put into place by family members. The appropriate signage was placed on the door to advise staff and visitors of the camera use. LSW-A stated the use of cameras should have been outlined in the care plan, and this task was the responsibility of the nurse manager in charge of R1's care. On 6/4/26 at 1:31 p.m. Social Services Director (SSD)-A stated the GSS 686 for R1 was obtained right away for consent for use of the camera, a sign was posted on the door, and administrative staff was notified. SSD-A stated R122's family member was contacted on 4/6/26 as well, and a consent was left for signature. The note left for family was to provide nursing staff with consent and were then able to proceed with use of the camera. SSD stated social services were responsible for obtaining the consent and posting the signage for camera use, however, nursing staff was responsible to update the care plan to reflect the use of the camera. On 6/4/26 at 10:55 a.m. registered nurse/clinical manager (CM)-B stated she was not working at the facility when the cameras were put into place. Both R1 and R122 had involved family members who had requested cameras to be put into use. CM-B stated signage was posted on the door to alert staff and visitors of the use of the camera. CM-B stated she had not completed the care plan process with R1 and R122.	20570		07/10/2026

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GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422**

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20570	Continued from page 9 The facility policy, Electronic Monitoring in Resident/Client/Patient Rooms-Enterprise, date reviewed/revised 5/18/26, initially referred to a separate policy: Photography and Video Imaging, Patient, Visitor, Workforce Member-Enterprise. This policy is broken by states which allows this monitoring. The document reflects for Minnesota, “residents or, under certain circumstances, their authorized resident representative, may conduct electronic monitoring in a resident’s room or private living space after certain conditions are met (such as written consent and notification, including that of any roommate). The procedure identified the electric monitoring device may be used by the resident, or their authorized representative if appropriate, after requirements have been met. This includes review of information required, and signature of a consent to allow such use. The procedure directs staff to have signs posted to inform staff/visitors of use. The policy lacks indication regarding placing the information in the care plan, or subsequent documentation in follow up regarding ongoing use of the video camera. A review of the policy, Photography and Video Imaging, Patient, Visitor, Workforce Member-Enterprise, date reviewed/revised 5/18/26, was completed and also reviewed the perimeters in which this was allowed, along with consent required for use. The facility policy, Care Plan-R/S, LTC, Therapy and Rehab, date reviewed/revised 12/1/25, indicated that “each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident’s optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs.” The policy stated further: “This plan of care will be modified to reflect the care currently required/provided for the resident.” SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		07/10/2026

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20995	Dietary Staff Requirements -Grooming. CFR(s): MN Rule 4658.0610 Subp. 3 Subp. 3. Grooming. Dietary staff must wear clean outer garments. Hairnets or other hair restraints must be worn to prevent the contamination of food, utensils, and equipment. Hair spray is not an acceptable hair restraint. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff consistently wore hair restraints and gloves while serving food. Additionally, the facility failed to maintain food temperatures within the desired range. The facility also failed to consistently cover food items placed in the freezer and date the items with the date placed and the date food items were to be used by. This had the potential to affect all 88 residents who resided at the nursing home. Findings include: On 6/1/26 at 5:11 p.m., dietary aide (DA)-A was observed setting up kitchenette area for evening meal service. DA-A had her hair pulled back in a ponytail, with strands of hair hanging free from the ponytail on the sides of her head. DA-A was wearing a standard uniform top. Further, Dietary manager (DM)-A delivered a tray of sherbet to the kitchenette without a hair net in place. At this time, DA-A removed the aluminum foil from the chafing dishes, stirred the chicken noodle soup, and began to prep for food service. DA-A applied a glove on the hand which handled the bread for the egg salad sandwich. DA-A removed the glove and replaced it with another glove, however, did not perform hand hygiene in between. At 5:16 p.m. DA-A had gloves on both hands while she removed the crusts from bread to prepare a sandwich. At 5:17 p.m., DA-A removed the second glove and did not perform hand hygiene. On 6/1/26 at 5:19 p.m., DA-A proceeded to check temperature of food items. DA-A reported the temperature of the egg salad filling for sandwiches was 56.8 degrees Fahrenheit (F). The egg salad sandwich filling was observed to be in a stainless serving container, sitting on the counter, and was not placed in an ice bath. DA-A also checked the temperature of the mashed potatoes and reported them to be at 115.5 degrees Fahrenheit. DA-A stated she was unaware of what temperatures food items were to be at.	20995	Corrected	07/10/2026

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20995	Continued from page 11 On 6/1/26 at 5:21p.m., DM-A returned to the kitchenette, wearing a hairnet, covered by a cloth visor. DM-A had brought out an apron for DA-A to wear. DM-A was informed of food temperature of egg salad filling and removed food item to take down to kitchen to chill. On 6/1/26 at 5:28 p.m., DA-A stated if staff wore a ponytail holder, a hairnet was not needed. DA-A stated her hair had not fallen out of the ponytail holder. DA-A stated she did not typically use a hairnet as she pulled her hair back into a ponytail. On 6/1/26 at 5:39 p.m., egg salad filling was brought back up to kitchenette in the stainless-steel serving container, placed in an ice bath. DM-A stated this was “blast chilled”, placed in a salted ice bath, while in freezer. The egg salad filling was temped at this time and was noted to be at 36.4 degrees F. DM-A stated temperature of cold food should be 40 degrees or less. DM-A stated there was no concern regarding salmonella for residents who had previously received sandwiches prior to temping as the filling was not out long enough in the “danger zone”. The potatoes were temped again at this time upon request and were noted to be at 160 degrees F. DM-A stated all hot food should be at 145 degrees F. DM-A stated when aware potatoes were at 116 degrees F., they should have been pulled, and a fresh batch made. DM-A stated she had realized she was not wearing a hairnet when delivering sherbet and went to obtain one. DM-A stated she had not noticed DA-A was not wearing a hairnet but should be. DM-A stated a hairnet was to be used to keep hair out of food. DM-A stated the expectation for those behind the serving line was to wear hairnets, aprons, and gloves on both hands. DM-A stated a ponytail was not adequate as a hair restraint. On 6/4/26 at 8:54 a.m., an observation was made during the breakfast service process in which DA-B was served breakfast while wearing a stocking cap which ended just under ears, and his hair was shoulder length and extended down to the neckline of shirt. On 6/4/26 at 9:35 a.m., DM-A stated DA-B should have worn a hairnet underneath the knit cap to restrain hair extending beyond the edge of the cap. The facility policy, Food Temperature Monitoring-Food and Nutrition Services, reviewed/revised 3/23/26, identified food	20995		07/10/2026

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20995	Continued from page 12 temperatures are taken and recorded before each meal service. The policy also identified temperatures are taken at other times during or at the end of meal service to ensure temperatures are held within acceptable ranges. The policy indicated that food was served at proper serving temperatures, and further identified proper temperatures as below 41 degrees Fahrenheit for cold foods or above 135 degrees Fahrenheit for hot foods. The facility policy, Employee Hygiene and Dress Code-Food and Nutrition Services, reviewed/revised 5/27/25, identified hairnets or hair restraints and beard nets or beard restraints were to be used when cooking, preparing, assembling food or ingredients. This includes dish rooms and storage areas. See specific state guidelines. Hair is to be covered completely. The policy further states aprons are to be put on a clean apron at the beginning of each shift. The facility policy, Hand Washing and Glove Use-Food and Nutrition Services, reviewed/revised 6/6/25, hands are washed thoroughly before putting gloves on and after taking gloves off. On 6/1/26 at 1:06 p.m. initial kitchen tour was conducted with dietary manager (DM)-A. The walk-in freezer had egg rolls on second shelf on right side of freezer. The egg rolls were wrapped with plastic wrap with one end opened to the air of the freezer. There was no date on the plastic wrap. There was a package of unidentified meat wrapped with aluminum foil, there was no date observed on the package. The walk-in cooler had a jar of Grey Poupon mustard with no date opened indicated, In addition there were hot dogs wrapped with plastic wrap and no date indicated on the wrap. On a shelf below a counter there was a large plastic tub of panko that was not dated when opened and placed into the plastic tub. DM-A stated items were expected to have an opened date and placed into appropriate containers; there was to be no items left open to the air. On a follow-up visit to the kitchen on 6/3/26 at 12:28 p.m. there was an opened undated package of pizza crust and a plastic bag of carrots in the walk-in freezer. DM-A stated the staff were usually	20995		07/10/2026

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20995	Continued from page 13 good about dating items when opened. Facility Food-Supply Storage–Food and Nutrition Services policy dated 3/13/26 indicated foods that had been opened or prepared were placed in an enclosed container, dated, labeled and stored properly. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure dietary staff are educated in expectation of hair net use, then could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20995		07/10/2026
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current	21390	Corrected	07/10/2026

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21390	Continued from page 14 standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to implement routine surveillance of signs and symptoms of illness/infection which were not currently being treated with antibiotic therapy or other treatment. This had the potential to impact all 88 residents who resided at the facility, as well as staff, and visitors. Findings include: A review of the Infection Surveillance Reports was completed for the months of March, April, and May of 2026. The documents included the total number of infections, whether facility or community acquired infections, the facility acquired infection incidence rates, and the number of multidrug resistant organisms (MDROs). The surveillance logs further classified the types by category of infection. The data gathered on this log included resident name, room number, infection type, signs and symptoms reported, and status (active or resolved). The log also included the type of treatment or antibiotic, antifungal or antimicrobial in place. The log lacked identification of completed testing (labs, chest x-ray, etc.). Although the logs contained an area for comments, this area was not utilized for reporting any completed lab results. During interview on 6/3/26 at 2:07 p.m., the Infection Preventionist (IP), also director of nursing (DON), stated she currently used the Point Click Care electronic medical record (EMR) for surveillance tracking. IP stated the PCC EMR was able to pull data up and input the information into the Infection Surveillance Report. The log lacked capability to pull testing and lab results into the form as they were not hyperlinked to the surveillance report. IP stated this information may be entered into the comment section, however, had not implemented this process. The infection control surveillance log lacked tracking instances of signs and symptoms presented which were not being treated with antibiotics, antifungals, or antimicrobials. IP stated although not tracked on the surveillance log, signs and symptoms of potential illness or infections were reviewed daily Monday through Friday by running reports and reviewing the documentation based on the control “f” (find) feature of the progress notes. IP stated when she reviewed the progress notes, she looked for things such as	21390		07/10/2026

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21390	Continued from page 15 an increase or decrease in temperatures and vital signs, symptoms of cough, shortness of breath, altered respiratory status, nausea, vomiting and diarrhea. The progress notes were also monitored for new admissions, indwelling devices, history of MDRO's, and new wounds. In addition to symptoms of illness/infection, a review of new orders was also completed. Upon demonstrating this process for the day of interview, the report generated 99 pages. Although the information was culled out for the day of review, this data was not recorded or compiled for subsequent review for trending of current trends of symptoms (urinary tract infections, upper respiratory symptoms, or gastrointestinal symptoms) or tracking for patterns of symptoms or trending of illnesses. IP stated she monitored the daily progress notes for symptoms of upper respiratory infections and if symptoms were noted, testing would be performed. IP stated the same process was used for symptoms of vomiting or diarrhea, and testing for c. diff (clostridium difficile). IP stated there were no formalized logs of those who were currently being monitored only and that data was captured only by running daily reports or review of individual progress notes. At the time testing was performed due to persistent symptoms, the individual would then be tracked on the "suspected" log. IP acknowledged the benefit of monitoring via the surveillance log signs and symptoms of infections and illness to capture any potential trends which would allow the opportunity to implement training, education, and placement of interventions to help decrease the potential for spread of illness and infection. The facility policy, Infection Prevention and Control Program, All Service Lines-Enterprise, reviewed/revised 3/25/26 identified the purpose of the infection control program was to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable diseases and infections. The policy identified the surveillance system was to be implemented to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable diseases and infections. Suggested Method of Correction The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program,	21390		07/10/2026

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21390	Continued from page 16 including tracking/trending of all illnesses in the facility. This process could include routine audits to ensure surveillance processes are in place on a real time basis. Additionally, the DON or designee could perform audits of immunization reviews for new admits, as well as administration of tuberculosis testing, along with administration of immunizations desired by residents/responsible party. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21390		07/10/2026
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to complete the second of the two step Mantoux process for 1 of 5 residents (R29) and 1 of 5 employees (E1). This had the potential to affect all 88 residents residing in the facility. Findings include: R29 was admitted to the facility on 4/29/26 at which time the symptom screen was completed and the two step skin test was completed. This was read as negative on 4/31/26 with negative results. A second step was not found on the electronic medical record. E-1 had a start date of 4/17/26. E-1's employee	21426	Corrected	07/10/2026

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21426	Continued from page 17 record identified a symptom screen was completed on 4/21/26, and the first step of the Mantoux was completed on 4/23/26 with a result of zero mm induration (raised red area) and read with a negative result. A second skin test was not completed. Upon follow up with facility in clarification, it was identified a second step was subsequently initiated on 6/3/26 following a request for Mantoux information. On 6/4/26 at 7:58 a.m., Infection Preventionist (IP) reviewed R29's electronic medical record (EMR) and identified only one step of the two-step skin testing was completed. At that time, results of E1's second Mantoux were requested as well. At this time, IP verified second step testing had not been completed for E1 and had been initiated on 4/3/26 after initial request for testing. A facility policy, Tuberculosis Control Plan for Employees, date reviewed/revised 3/2/26, was reviewed and identified the purpose of screening employees was to provide early identification of employees infected with Mycobacterium tuberculosis and prevent the spread of infection through appropriate screening and treatment of employees. The procedure outlines the procedure for Tuberculin Skin Tests (TSTs) as follows: The facility will screen employees upon hire for signs and symptoms of tuberculosis. For a two-step TST, administer the first TST upon admission and read 48-72 hours after administration. If the first TST is negative, administer a second TST 1-3 weeks after the first TST and read 48-72 hours after administration. A facility policy, Tuberculosis Control Plan for Residents, date reviewed/revised 3/2/26, identified screening of residents was completed to provide early identification of residents/patients infected with Mycobacterium tuberculosis and prevent the spread of infection through appropriate screening, placement, and treatment of residents/patients. The process for screening residents was also completed upon admission, followed by the process for a two step TST. This was to be completed within the same time frame as the employee testing was to be completed. SUGGESTED METHOD OF CORRECTION: The administrator and/or director of nursing (DON) could review, revise, or create policies and procedures for tuberculosis prevention. Staff should be educated to those changes. The DON or designee, should routinely audit to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance.	21426		07/10/2026

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21426	Continued from page 18 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		07/10/2026
21620	Labeling of Drugs CFR(s): MN Rule 4658.1345 Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to assure medication labels properly reflected provider orders for 2 of 7 residents (R110, R89) observed during medication administration. Findings include: On 6/1/26 at 4:10 p.m., medication observation was completed with licensed practical nurse (LPN)-A during R110's medication pass. LPN-A provided R110 with quetiapine fumarate 25 mg ½ tablet (1/2 tablet to total 12.5 mg-milligram/a unit of measurement) at that time, however, medication label read to give ½ tab(let) daily and went on to direct staff to give one tablet (25 mg) at bedtime. LPN-A stated medication administration record (MAR) directed staff to give at 4:00 p.m. LPN-A stated she was unsure if the previous dosing schedule had changed. LPN-A stated the medication label should match the orders on the MAR. LPN-A stated there were stickers available to place on the prescription label to identify a change in orders but acknowledged there was no label in place. Upon review of the orders, it was noted the orders directed staff to give quetiapine fumarate 25 mg ½ tablet (12.5 mg) by mouth one time a day for depression at 4:00 p.m. and 25 mg by mouth one time a day for depression at 8:00 p.m. On 6/4/26 at 1:30 p.m., a review of the medication label and the prescription label was completed with the clinical manager (CM)-A. The label directed staff to administer ½ tablet (12.5 mg) by mouth once daily. Give one tablet (25 mg) at bedtime. CM-A acknowledged the label lacked indication regarding spacing of doses. CM-A stated there were stickers available to place on label to direct staff to electronic medical record.	21620	Corrected	07/10/2026

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21620	Continued from page 19 On 6/3/26 at 7:47 a.m., registered nurse (RN)-B provided R89 with the inhaler, Anoro Elipta, for one puff inhalation. The inhaler was noted to be in a plastic tray, and lacked any labeling to include resident name, medication date of dispensing, date of expiration, or directions for use. The inhaler was dated as opened 4/29/26. Additionally, resident was administered the following doses of insulin: Lantus Insulin (Insulin Glargine Subcutaneous Solution 100 mg/ml) 38 units sub q (within the upper level of flesh, but not into the muscle) however the label directed staff to administer 40 units sub q. Novolog Insulin Aspart Injection 100 unit/ml 11 units, however, the label directed staff to administer nine units of insulin sub q. RN-B stated the insulin labels should have been updated by pharmacy to reflect the current doses ordered, or a sticker should have been placed on the insulin pens to reflect there was a change in orders and to refer to the EMR. RN-B stated the inhaler should remain in the original packaging until supply was depleted. On 6/4/26 at 7:58 a.m., director of nursing (DON) stated all medications should be labeled with the resident's name, name of medication, date dispensed, med dispensed, date of expiration, and directions for use. DON stated the labels on the medication card should match the instructions on the MAR. If there were changes to the orders, there were stickers which would be placed which identify directions were changed and direct staff to refer to EMR. The facility policy, Medications: Administration Including Scheduling and Medication- R/S, LTC, date reviewed/revised 3/30/26, identified with medication pass, the staff were directed to read the label on the medication container and compare with the MAR when removing the container from the supply drawer. The policy lacked direction as to what to do if there were a discrepancy between the label and the prescription label. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications and or/ storage of items in the medication room or refrigerators. Nursing	21620		07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/04/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21620	Continued from page 20 and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		07/10/2026