



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2026

Administrator
KITTSOON HEALTHCARE
1010 SOUTH BIRCH AVE
HALLOCK, MN 56728

RE: CCN: 245247

Cycle Start Date: July 30, 2026

Dear Administrator:

On July 30, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 28, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 28, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 28, 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 28, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility.

Therefore, Kittson Healthcare will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 28, 2026.

You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 30, 2027 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

An equal opportunity employer.



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Administrator
KITTSOON HEALTHCARE
1010 SOUTH BIRCH AVE
HALLOCK, MN 56728

Re: State Nursing Home Licensing Orders
Event ID: 235C95-H1

Dear Administrator:

The above facility survey was completed on July 30, 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:

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

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: 245247		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
NAME OF PROVIDER OR SUPPLIER KITTSO N HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH AVE , HALLOCK, Minnesota, 56728			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/30/2026. At the time of this survey, Kittson Memorial Healthcare Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/22/2026

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

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Kittson Memorial Healthcare Center is made up of two buildings. The original building is north of and separated from, with a 2-hour fire barrier, the Kittson Memorial Hospital building. It is 1-story with a basement and was constructed in 1968 that was determined to be of Type II (000) construction and is now fully sprinkler protected and is called the upper level. In 1981 a 1-story addition without a basement was built to the north of the original building that was determined to be of Type V (111) construction. Non-fire retardant treated wood was discovered in the construction of spaces in the 1968 building which reduced the overall construction type to type V (111) and it was surveyed as one building. The facility has a capacity of 50 beds and had a census of 44 at the time of the survey.			K0000			08/22/2026
K0511 SS = F Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical			K0511	The transfer switch room located in the Nursing Home was blocked. As of 7/31/2026 the manager of activities began cleaning out the area and the manager of maintenance finished painting a caution zone to ensure an open and unblocked electrician workspace on 8/7/2026. The manager of Activities communicated with their		08/07/2026

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K0511 SS = F Bldg. 01	Continued from page 2 wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide a clear path to electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.1.2 and NFPA 70 (2012 edition), National electrical Code, sections 110.26 (A) (2). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2026 at 12:35pm, it was revealed by observation that the electrical panel located in the Transfer Switch Room was blocked by storage materials. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0511	Continued from page 2 staff that items cannot be placed in front of the panels or the door (the painted caution zone). During weekly generator inspections, the transfer switch is also inspected, and the manager of maintenance will ensure nothing is piled in front of panels or in the newly designated caution zone. The manager of maintenance and his maintenance workers will be responsible for ensuring the designated caution zone is clear of obstructions when completing the weekly generator inspections. This was completed on 8/7/2026.		08/07/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility.			K0712	On 7/30/2026 it was revealed that the fire drills did not meet the varying time requirements. The manager of maintenance will pay attention to timing and when drills are completed with the 2-hour variance implemented. The manager of maintenance will be responsible for ensuring the new drills are conducted with the 2-hour variance implemented by recording previous times and planning appropriate future drill times. These will be checked monthly. This will be implemented for the next drill during the week of 8/1/2026 and monthly moving forward.		08/01/2026

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K0712 SS = F Bldg. 01	Continued from page 3 Findings include: On 07/30/2026, at 11:30am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: third shift 03/03/26 at 10:00pm, 06/29/26 at 10:05pm and 09/29/2026 at 10:15pm. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0712			08/01/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2026, 11:04am, it was revealed by review of available documentation the required annual door inspection documentation showing the 11 points of inspection was meet was not available at the time of the survey. An interview with the Maintenance Director verified			K0761	Our annual door inspection was not completed at the time of inspection. Our plan is to complete the yearly inspections in the first quarter of the year. This task was added to the Maintenance Inspections checklist under yearly to be done in the first quarter of every year by the manager of maintenance or designee assigned by the manager. The manager of maintenance will monitor and review the maintenance inspections checklist during daily operations for accurate planning and upkeep. This was completed on 8/14/2026 for the 2026 year.		08/14/2026

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K0761 SS = F Bldg. 01	Continued from page 4 this deficient finding at the time of discovery.			K0761			08/14/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 07/30/2026, at the following times, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following locations; 1) At 11:58am, above double doors leading into Up North Dining Room 2) At 12:11pm, above double doors leading into the West Corridor An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0372	The organization failed to maintain the smoke barrier in which there was a penetration running from one smoke compartment to another above doors. It was noted that when outside contractors are here, they need to be monitored and it must be communicated to them that they must fire caulk around the penetrations. Both the manager of maintenance and the manager of IT will be responsible for monitoring outside contractors when doing work at the organization that ensures that any penetration is properly sealed. This was completed on 7/31/2026.		07/31/2026
K0753 SS = E Bldg. 01	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations			K0753	There were too many decorations/items hanging on residents' doors in the Nursing Home. The NH DON and Manager of Activities have communicated to staff that no more than 20% of the surface area of residents doors can be covered with		08/20/2026

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K0753 SS = E Bldg. 01	Continued from page 5 Combustible decorations shall be prohibited unless one of the following is met: - o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. - o Decorations meet NFPA 701. - o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. - o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). - o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This STANDARD is NOT MET as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to prohibit combustible decorations per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.5.6 and 19.7.5.6 (4). These deficient findings could have a patterned on the residents within the facility. Findings include: On 07/30/2026, at the following times, it was revealed by observation that excessive decorations were on patient room doors in the following locations. These decorations cannot exceed 25% of the door surface. 1) at 12:22pm, room 103 2) at 12:25pm, room 131 3) at 12:26pm, room 130 4) at 12:27pm, room 127, room 126, room 125 and room 124 An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0753	Continued from page 5 too many decorations and/or any combustible decorations. The NH DON is also making and sending a letting to go out to residents families informing them of this policy. This will be monitored during Maintenance daily rounds and the NH DON, manager of activities, and manager of maintenance are responsible for the correction and monitoring of continued compliance. This was completed on 8/20/2026		08/20/2026
K0223 SS = D Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101			K0223	A door at the activities storage room did not close and latch when tested. This room was recently made into a storage room from a previously existing office so there was no door closure.		07/31/2026

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K0223 SS = D Bldg. 01	Continued from page 6 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure that the doors to high hazard room would close and latch with power of self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/30/2026, at 12:47pm, it was revealed by observation that the door at the activities storage room did not close and latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0223	Continued from page 6 Manager of maintenance or a designee will mount a door closure and maintenance will communicate with all department heads on current and future uses of spaces and/or rooms stressing the need for potential door closures. The manager of maintenance will be responsible for corrective action on this matter and all department heads alongside the manager or maintenance/designee will be responsible for monitoring compliance when a change is necessary. The corrective action for this was completed 7/31/2026.		07/31/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			K0353	This was a deficiency referring to 18" of clearance to the ceiling because of it being a sprinklered room, however, this is not a sprinklered space. Rather it has the appropriate audio/visual alarms as required. The process in place for maintaining the required 18" clearance in sprinklered spaces is audited during regularly scheduled environmental safety rounds. If noncompliance is discovered, it is automatically communicated with the respective department manager and resolved immediately. Will continue to audit per standing routine process. The maintenance manager or designee is		07/31/2026

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K0353 SS = D Bldg. 01	Continued from page 7 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 spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1. 2.. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/30/2026, at 12:52pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in IT Office. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0353	Continued from page 7 responsible.		07/31/2026
K0781 SS = D Bldg. 01	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to implement its portable space heater policy			K0781	There was a finding of a space heater in the NH DON office that did not meet requirements of a label not exceeding 212 degrees F. The facility will upgrade our policy to outline and meet state standards. We plan to communicate to office staff when onboarding that they must read and follow the update policy put in place 8/28/2026. Maintenance manager/designee will be responsible for monitoring appliances and space heaters ensuring proper labels and up to proper policy standards. This was completed on 7/30/2026. The new policy will be reviewed and revised by 8/28/26.		08/28/2026

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K0781 SS = D Bldg. 01	Continued from page 8 per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/30/2026, 12:31pm, it was revealed by observation of portable space heaters in Director of Nursing Office could not be verified that it meets all the requirements for a healthcare facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0781			08/28/2026
K0918 SS = D Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day 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			K0918	We were unable to provide documentation of diesel fuel testing for the generators. The manager of maintenance added to the maintenance inspections checklist for yearly testing to be done by interstate power company every spring. This will be monitored yearly by the manager of maintenance during the annual inspections. We tested on 8/18/2026 and we are no waiting for the lab results from the outside vendor.		08/18/2026

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K0918 SS = D Bldg. 01	Continued from page 9 staff interview, the facility failed to maintain generators per NFPA 101(2012 edition) Life Safety Code, 9.1.3.1, NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2. and 8.3.8. This deficient finding could have an isolated on the residents within the facility. Findings include On 07/30/2026, at 11:32am, it was revealed by a review of available documentation at the time of the survey the facility could not provide a letter of reliability and/or a fuel testing document from a fuel company. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0918			08/18/2026
K0921 SS = D Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a policy			K0921	The information requested was provided in a large document. Our outside vendor denied being able to extract the information to show the equipment list specifically. We will communicate and work with the vendor for the following year on the expectations of a document/packet that is easier to decipher or meet compliance requirements. Communication started on 8/20/2026 with outside vendor. Completion is expected for next annual inspection.		08/20/2026

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K0921 SS = D Bldg. 01	Continued from page 10 for appliances not supplied by the facility per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/30/2026 at 11:47am, it was revealed by a review of available documentation that the facility could not provide documentation for the testing of electrically powered medical equipment that showed the equipment list. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0921			08/20/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 22, 2026

Administrator
KITTSOON HEALTHCARE
1010 SOUTH BIRCH AVE
HALLOCK, MN 56728

RE: CCN: 245247
Cycle Start Date: September 3, 2026

Dear Administrator:

On September 3, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads '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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 22, 2026

Administrator
KITTSOON HEALTHCARE
1010 SOUTH BIRCH AVE
HALLOCK, MN 56728

Re: Reinspection Results
Event ID: 235C95-H2

Dear Administrator:

On September 3, 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 July 30, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads '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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E0000	Initial Comments On 7/27/26 through 7/30/26, 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				
F0000	INITIAL COMMENTS On 7/27/26 to 7/30/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H5274304C (MN2722541), no deficiency was issued. 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				
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -		F0689				

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0689 SS = G	Continued from page 1 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a safe environment by ensuring appropriate precautions remained in place while a freshly mopped floor was wet for 1 of 2 residents (R25) reviewed for falls and failed to provide transfer assistance in accordance with the resident's care-planned interventions for 1 of 1 resident (R9) reviewed for transfer assistance. This resulted in actual harm for R25 when she slipped and fell on the freshly mopped, wet floor, struck her head on the concrete floor, and sustained a head laceration that required emergency medical evaluation and staples. Findings include: R25 R25's annual Minimum Data Set (MDS) dated 4/21/26, identified R25 had intact cognition, was independent with activities of daily living (ADLs), transfers and ambulation. R25 had not experienced any falls since admission and/or the previous assessment. Diagnoses included repeated falls, dysthymic disorder, unspecified intracranial injury, osteoporosis, essential tremor, paroxysmal vertigo, gait and mobility abnormalities, weakness, urinary incontinence, seizures and disorientation. R25's care plan dated 5/5/26, identified an activity of daily living status. R25 believed herself capable of increased independence with bed mobility, transfers, walking in room and hall, dressing, eating, toilet use and personal hygiene. A goal was identified R25 would accept limitations of unsteady gait and function at her maximum capacity as evidenced by walking with staff when out of her room. Approaches included that R25's usual performance was substantial assist with bathing, supervision with shower transfer and setup with eating. R25 was independent with all other abilities. During interview on 7/27/26, at 6:49 p.m. R25 stated she had fallen in her room a few weeks prior, when she trying to go to the bathroom. The housekeeper had just mopped the floor, and she had slipped on the wet floor and fell. R25 stated she hit the back of her head on the floor during the fall and had to go to the emergency room where she received stitches to the back of her head. R25 stated a wet floor sign had not been placed, and she was not aware her floor was wet when she tried to ambulate to the			F0689	Continued from page 1 head laceration. The resident's fall risk and plan of care was reviewed and updated as indicated. R9: Transfer status and current level of assistance will be reviewed by nursing and therapy as appropriate. The care plan and staff communication tools; resident care slips will be reviewed/revised as needed to clearly identify the required number of staff for transfers. Staff assigned to R9 will be re-educated on the resident's current care-planned transfer status. How the facility will identify other residents having the potential to be affected by the same The DON/designee reviewed residents identified as requiring transfer assistance to verify that current transfer status is accurately reflected in the care plan and staff communication tools. The Environmental Services Supervisor/designee reviewed housekeeping practices for resident rooms and common areas to verify availability and use of wet-floor signage and procedures for keeping residents away from wet surfaces until floors are dry. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. The facility will review/revise its fall prevention, safe-environment, housekeeping, and transfer-assistance procedures. Housekeeping personnel will be educated that: • wet-floor signs will be placed before or immediately upon beginning wet-floor cleaning; • residents present in the area will be notified of the wet floor; • signs will remain in place until the floor is fully dry; • floors will be dry-mopped when necessary; and • whenever practical, resident rooms will be mopped while the resident is outside the room. Nursing personnel will be re-educated that current transfer instructions in the care plan must be followed and that staff may not independently reduce the required level of assistance based solely on the resident's apparent ability at that moment.		09/02/2026

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F0689 SS = G	Continued from page 2 bathroom. R25' The Patient/Resident Event Report Form dated 6/7/26, at 11:30 a.m. identified R25 had an unwitnessed fall in her room. The report identified R25 was coming out of the bathroom and the floor was wet and she slipped and hit the back of her head on the concrete floor. A one-to-two-centimeter laceration and egg like bruise was observed on the back of R25's head and she was sent to the emergency room to evaluate. Listed actions taken included assist of one in room and a physical therapy evaluation. The floor was confirmed to be wet. R25's CT Spine Cervical Without Contrast Results dated 6/8/26, identified R25 had a CT of the brain and cervical spine was performed. There were no acute intracranial process and no acute fracture; however, the CT results did identify R25 did have a head laceration. No further hospital documentation was received from the facility. R25's progress note(s) identified the following: 6/7/26, R25 was found on her bedroom floor with a moderate amount of blood on the floor and the back of her head. R25 had stated she was up to use the restroom, but the floor had just been mopped and was slippery. R25 had slipped and fell and hit the posterior right side of her head. Area of head was cleansed and there was a one-to-two-centimeter laceration and a five-centimeter egg lump on the back of her head. R25 denied pain and pupils were equal and reactive to light. Range of motion and hand grasps were within normal range. R25 was sent to the emergency room for further assessment. 6/7/26, R25 returned from the hospital at 1:30 p.m. and had received 8 staples to the back of her head. 6/13/26, identified the staples were present and the wound was dry, intact and had no signs of infection. During interview on 7/28/26, at 9:11 a.m. the director of nursing (DON) stated the event report was the only information on the fall and did not have evidence of an internal investigation into the events that lead to the missing wet floor sign or what corrective measures were taken by the facility following the fall. During interview on 7/29/26, at 7:03 a.m. housekeeper (HK)-A stated she usually waited to clean and mop resident rooms when the resident went out for meals or activities. If HK-A had to clean a room when the resident was there, she reminded the resident the floor was wet and to be careful and she always dry mopped the floor after mopping to ensure the floor was not to wet. HK-A stated she always placed a wet floor sign in the resident's doorway as well. The housekeeping staff had been told a resident had fallen on a wet floor			F0689	Continued from page 2 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Environmental Services Supervisor/designee will audit wet-floor practices 5 observations per week for 4 weeks, then 5 observations monthly for 2 months. Audits will include proper signage, resident notification, and confirmation signage remained until the surface will be dry. The DON/designee will audit 5 residents requiring transfer assistance weekly for 4 weeks, then monthly for 2 months to verify the care plan accurately identifies transfer status and observe staff follow the identified level of assistance. Audit results will be reviewed through QAPI. Identified noncompliance will result in immediate corrective action and additional education, and monitoring will be extended as indicated. The date each deficiency will be corrected. September 2, 2026		09/02/2026

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F0689 SS = G	Continued from page 3 and were given reminders to be sure to wring out their mops better, so the floor would not be too wet, as well as to use a dry mop over it. The housekeeping staff had also been told to inform the resident the floor was wet and to place a wet floor sign in their room. During observation on 7/29/26, at 11:36 a.m. HK-A was observed mopping a resident's room. The resident had exited the room to go to lunch and HK-A had wet mopped the floor and then used a dry mop to go over the entire floor. When she was finished, HK-A placed a wet floor sign in the doorway to the room. During interview on 7/30/26, at 9:35 a.m. HK-B stated she had mopped R25's floor on 6/7/26. HK-B did not know R25 was in the room when she cleaned, as she must have been in her bathroom at the time. Mopping was the last thing HK-B did before she finished the room. When HK-B heard R25 had fallen, the staff had told her there was no wet floor sign in the resident's room. HK-B was sure she had used one, but she may have taken it down to soon, before the floor was fully dry. A few of the facility nursing assistants had told her about it the next time she returned to work, however, no one else had talked to her about it or provided education. She did not think anyone else knew it was her that had cleaned the room that day. During an interview on 7/30/26, at 10:06 a.m., the DON stated that following R25's fall, she met with staff who had been working that day. Staff confirmed R25's floor had been wet at the time of the fall. The housekeeper had recently mopped R25's floor and reported reminding R25 that the floor was wet; however, a wet-floor sign had not been placed. The DON stated she spoke with the housekeeping supervisor (HS)-C regarding the incident and understood that HS-C had spoken with the involved housekeeper and provided education. The DON was not able to provide evidence of staff education following the fall. During interview on 7/30/26, at 11:04 a.m. HS-C stated she had been notified a resident had fallen because of a freshly mopped floor about a week after the fall had occurred. HS-C had been told that a resident had gotten up to go to the bathroom, and the floor was wet from the housekeeper mopping and the resident had slipped and fell; however, was not aware of the injury. She had talked with the housekeepers and HK-B stated she had cleaned the room and then mopped the floor. HK-B said she had put a wet floor sign up and told the resident to be careful the floor was wet, but that she may have removed the wet floor sign to soon, before the floor was dry. HS-C reminded all her staff frequently about using the wet floor signs as they were there to protect the housekeeper as well as to alert others the floor was wet. The housekeepers did put the wet floor signs in			F0689			

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F0689 SS = G	Continued from page 4 the resident doorways and not in the resident's room as they did not want the residents tripping over the sign and also to alert staff coming in the room that the floor was wet. Most of the time the resident was not in the room during cleaning. That day the weather was very hot, and the facility air conditioner was not working, which may have contributed to delay drying of the mopped floor. HS-C had not done any formal audits of compliance using the wet floor signs or documented the actions and education that was provided to the housekeeper and the rest of the housekeeping staff. R9R9's annual MDS dated 4/17/26, identified R9 had severe cognitive impairment and required maximal assistance with dressing, grooming and toileting hygiene. R9 was dependent with transfers and bed mobility and was unable to ambulate. R9 did not have behaviors of rejection of care. Diagnoses included Alzheimer's disease, abnormal gait and mobility, history of transient ischemic attack (TIA) and stroke, heart disease and dementia. R9's care plan date dated 4/30/26, identified an ADL functional status with a goal R9 would not deteriorate as evidenced by maintaining her ability to be independent with bed mobility, transfers, walking and eating after setup. Approaches were listed and included R9's usual performance was substantial assistance with toileting hygiene, bathing, dressing, partial assist with eating, and dependent with all other functional abilities. R9 was unable to ambulate and was switched to a two person stand and pivot transfer. During observation on 7/29/26, at 12:07 p.m. nursing assistant (NA)-C was assisting R9 from the bed to the wheelchair. NA-C assisted R9 to sit on the side of the bed and placed a gait belt around R9's waist. NA-C assisted R9 to stand and pivot transfer to her wheelchair. NA-C noted a need to check for incontinence care and proceeded to assist R9 back into bed for incontinence care. R9 had difficulty coming to a standing position, so NA-C called on his walkie talkie for assistance. NA-D entered the room and assisted NA-C to help R9 into a standing position and pivot transfer back into bed. NA-D exited the room and NA-C provided incontinence care to R9. NA-C assisted R9 back to a seated position on the edge of the bed and placed a gait belt around R9's waist. NA-C assisted R9 to stand and then pivot back into her wheelchair without another staff's assistance. NA-C then wheeled R9 to the dining room for lunch. During interview on 7/29/26, at 12:15 p.m. NA-C stated R9's ability to stand varied day to day and			F0689			09/02/2026

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F0689 SS = G	Continued from page 5 R9 was mainly an assist of one with transfers. Sometimes R9 was an assist of two for transfers and had to call for help when she had trouble with standing. R9 stood fine most of the time. When interviewed on 7/29/26, at 12:34 p.m. registered nurse (RN)-C stated R9 was an assist of two to transfer per the care plan. NA-C should have had two persons assist when assisting R9 to transfer in case something happened, like if she fell. During interview on 7/29/26, at 2:12 p.m. RN-A stated R9 was assist of two to transfer and was not able to ambulate. The nursing assistants were trained for what type of care each resident needed during their orientation. There was also a list on the nursing assistant clip board that listed all the changes with the residents, including any therapy changes. The nursing assistants also had access to the resident's care plans. During interview on 7/30/26, at 10:30 a.m. the DON stated R9's ability fluctuated from day to day and had recently had an increase in staff support for assistance. When changes were made to a resident's plan of care for increase assistance, it was passed on in shift reports and discussed in daily huddles. Staff should follow the resident plan of care. The DON was sure it had been passed on in huddle and shift report but was not able to find the notes. The facility's Fall Prevention Program dated 3/20/26, identified goals that included to provide a comprehensive fall preventions program aimed at promoting patient safety with participation by the entire organization. Patients, residents, families and staff would be educated as appropriate on measures to prevent falls and implement interdisciplinary fall prevention interventions tailored to the resident. The plan identified universal fall precautions were to be implemented for all residents, as they were aimed at keeping the care environment safe. Universal fall precautions identified several approaches, which included to keep floor surfaces clean and dry and clean up all spills promptly.			F0689			09/02/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to			F0880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R18: Enhanced Barrier Precautions (EBP) status will be reviewed. Appropriate EBP signage and PPE supplies will be placed/verified at the point of care. The care plan will be updated as necessary. Staff providing high-contact care will be educated		09/02/2026

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F0880 SS = F	Continued from page 6 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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			F0880	Continued from page 6 regarding when gown and glove use is required. R29: EBP status will be reviewed based on the resident's wound status. The care plan and precaution signage will be corrected to accurately identify EBP requirements. Staff providing high-contact care will be educated regarding appropriate gown and glove use. R1: The resident's gastrointestinal symptoms and subsequent condition will be reviewed. Infection surveillance documentation will be updated as appropriate, and nursing/IP staff reviewed the expectation that signs and symptoms of possible infection are included in surveillance even when an antibiotic has not been initiated. How the facility will identify other residents having the potential to be affected by the same The Infection Preventionist/designee completed a review of current residents with: • indwelling medical devices; • wounds; • known MDRO colonization/infection; or • other indications for EBP. The facility also reviewed recent nursing documentation for residents with signs or symptoms of potential respiratory, gastrointestinal, urinary, skin, or other infectious conditions to ensure appropriate inclusion in surveillance tracking. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. The facility reviewed/revised its EBP and infection-surveillance process. Licensed nurses and nursing assistants routinely providing care in the nursing facility, and other applicable staff will be educated regarding: • indications for EBP; • high-contact resident care activities requiring gown and glove use; • location and use of PPE;		09/02/2026

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F0880 SS = F	Continued from page 7 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement Enhanced Barrier Precautions (EBP), including the use of gowns and gloves during high-contact resident care activities, f1 of 1 resident (R18) reviewed for catheters and 1 of 1 resident (R29) reviewed who was receiving wound care. In addition, the facility failed to conduct ongoing infection surveillance to identify and track residents with signs and symptoms of potential infection for 1 of 1 resident (R1) reviewed for infection surveillance. Findings include: R18 R18's quarterly Minimum Data Set (MDS) dated 6/8/26, identified moderate cognitive impairment and was incontinent of bowel and bladder. R18's diagnoses include chronic kidney disease stage 3 and retention of urine-chronic (long term). R18's Health Service Referral Form discharging hospital dated 6/17/26, identified R18 was admitted back to the facility following hospitalization with a discharge plan of maintaining Foley (indwelling) catheter related to urine retention. R18's provider orders dated 6/26/26, identified R18 had a Foley catheter. During observation on 7/29/26 at 7:09 a.m., registered nurse (RN)-A had just completed a dressing change and assisted R18 to get comfortable in bed by placing pillows under his head and behind his back and then covered him with a blanket while waiting for the nursing assistant (NA)s to come in			F0880	Continued from page 7 • proper precaution signage; • inclusion of EBP status in the care plan; and • prompt communication of changes in precaution status. Nursing and Infection Prevention staff will be educated that surveillance includes signs and symptoms of possible infection, not only diagnosed infections or residents receiving antibiotics. A process will be implemented for nursing to communicate symptoms to the Infection Preventionist in real time or according to the facility surveillance procedure rather than relying solely on retrospective month-end review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Infection Preventionist/designee will conduct 5 EBP observations weekly for 4 weeks and monthly for 2 months, including PPE selection, signage, and care-plan accuracy. The IP/designee will audit the infection surveillance system weekly for 4 weeks and monthly for 2 months to compare nursing notes/change-in-condition documentation against the surveillance log and ensure potentially infectious symptoms are tracked. Results will be reported to QAPI with corrective action and additional education for identified variances. The date each deficiency will be corrected. September 2, 2026		09/02/2026

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F0880 SS = F	Continued from page 8 and assist R18 with getting dressed. RN-A was not wearing a gown while assisting R18 with bed mobility. During observation on 7/29/26 at 7:11 a.m., NA-A and NA-D entered the room and assisted R18 in getting dressed. Both NAs sanitized their hands and put on gloves prior to assisting R18. The NAs assisted R18 to roll from side to side, placed an incontinent brief, shirt and socks on. NA-A unwrapped the Foley catheter tubing from around R18 leg before threading it through R18's pants leg. NA-A then washed hands with soap and water in the bathroom. In the bathroom there were gowns and gloves on the door with a sign identifying enhanced respiratory precautions. NA-A came back out of bathroom and placed gloves on and NA-A and NA-D placed transfer sling under resident and used a total lift to transfer him to the wheelchair. During observation on 7/29/26 at 7:29 a.m., the hospital lab tech (HLT) entered R18's room to draw blood from R18. The HLT sanitized his hands and prepared his supplies, then sanitized his hands again and put on gloves and drew 2 vials of blood from R18. HLT was only wearing gloves when in direct contact with resident. During an interview on 7/29/26 at 7:29 a.m., the HLT stated he did not know R18 was on EBP and pointed out there was no signage to indicate EBP and did not get an update from staff. If I had known, I would have worn a gown and gloves. During an interview on 7/29/26 at 8:29 a.m., NA-A stated their understanding was they would only need to wear a gown and gloves while providing catheter care and did not do it with other direct resident contact. There were PPE supplies in the R18's bathroom for use with catheter cares. During an interview on 7/29/26 at 9:53 a.m., NA-D stated they had only been working at the facility for a couple of weeks and got three days of orientation. During the time it was explained they would need to wear a gown and gloves when doing catheter care for R18, or if the nurse was doing a dressing change. She stated she had not realized R18 was on EBP and stated it was not on the Kardex (a quick reference for care plan). During an interview on 7/29/26 at 2:10 p.m., the director of nursing (DON) stated staff were expected to use EBP with residents when they provided any catheter cares or wound dressings. The DON also touched base with infection preventionist when any			F0880			09/02/2026

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F0880 SS = F	Continued from page 9 precautions are instituted. Staff were also expected to follow the policy if there are any questions. R29 R29's quarterly MDS dated 6/20/26, identified R29 had moderate cognitive impairment and diagnoses that included chronic heart failure, pressure ulcer, peripheral vascular disease and chronic kidney disease. R29 was at risk for developing pressure ulcer/injury and had no unhealed pressure ulcer/injuries. R29 used a pressure reducing device for her bed and chair and had an application of a nonsurgical dressing. R29's care plan revised 7/12/26, failed to identify R29's need for enhanced barrier precautions due to having a pressure ulcer. During an observation on 7/29/26 at 7:33 a.m., NA-A and NA-B entered R29's room but did not put on a disposable gown. Both walked past the personal protective equipment cart hanging on the backside of R29's bathroom door. There were disposable gowns and gloves available with signage indicating R29 required contact precautions. At 7:34 a.m., R29's foam border dressing was loose and no longer covered R29's pressure ulcer wound. NA-A and NA-B assisted R29 to use the bedpan, then transferred R29 from her bed to the wheelchair using a fully body mechanical lift. At 7:43 a.m., NA-A and NA-B removed their soiled gloves and assisted R29 to the shower room. At 8:16 a.m., NA-A and NA-B returned to R29's room with R29 and transferred R29 back into bed using a full body mechanical lift to finish dressing. R29's foam border dressing had been removed and R29's wound was exposed. Neither NA-A nor NA-B were wearing disposable gowns. At 8:47 a.m., registered nurse (RN)-A entered to assist R29 with her stockinette and to assess R29's wound. RN-A did not put on a disposable gown. During an interview on 7/29/26 at 8:59 a.m., NA-A and NA-B Earnistine stated R29 has a wound, so staff always had to wear gloves but pointed to the			F0880			09/02/2026

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F0880 SS = F	Continued from page 10 sign and stated if there's any drainage then they had to wear a gown. Only then. During an interview on 7/29/26 at 9:05 a.m., RN-A stated staff only needed to wear a gown and gloves when doing the dressing for the wound and it was not needed at any other time. During an interview on 7/29/26 at 12:25 p.m., DON and RN-B stated staff were expected to wear a gown and gloves during wound care and when R29 needed to use the bed pan, potentially. The DON stated she was unaware that a contact precautions sign was hanging on R29's PPE cart and it should have been enhanced barrier precautions because R29 had a pressure ulcer. Staff were expected to follow Centers for Disease Control and Prevention (CDC) guidelines and wear a disposable gown and gloves whenever providing care for R29 to prevent the potential transmission of infection to R29. A facility policy related to Enhanced Barrier Precautions was requested but not received. The Centers for Disease Control and Prevention guidance dated 6/28/24, identified Enhanced Barrier Precautions were an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). SURVEILLANCE R1 R1's quarterly MDS dated 5/28/26, identified R1 had a moderate cognitive impairment and diagnoses that included Post Traumatic Stress Disorder (PTSD) and anxiety. R1 was independent with eating, toileting, hygiene, transfers and walking. R1's care plan revised 5/30/26, identified R1 experienced differences in ability to perform activities of daily living (ADLs) related to dementia. Staff were directed R1 was independent with eating, toileting, hygiene, dressing/footwear, bed mobilities, transfers and walking. Supervision of 1 with personal hygiene and substantial assist of 1 with bathing. R1's nursing note dated 7/25/26 at 5:34 p.m., identified R1 refused to eat breakfast, said she was			F0880			09/02/2026

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F0880 SS = F	Continued from page 11 not hungry. Did take 240 milliliter (ml) chocolate ensure (nutritional shake) with her medications. R1 said she had been sick with diarrhea. The facility Nursing Home Infection Control Log dated May 2026, identified the resident name, date, onset date, site, infection related diagnosis, culture yes/no, organism, antibiotic, isolation yes/no, nosocomial (did the infection originate in the facility) yes/no and follow up. The log identified 1 cellulitis (a common, potentially dangerous skin infection), 3 urinary tract infections (UTI), 1 leg wound and 1 paronychia (an infection or inflammation of the skin fold around a fingernail or toenail). Only 1 culture was identified, and 1 UTI provided no further information. Additionally, the log failed to identify any infectious symptoms not treated with an antibiotic. The facility Nursing Home Infection Control Log dated June 2026, identified the resident name, date, onset date, site, infection related diagnosis, culture yes/no, organism, antibiotic, isolation yes/no, nosocomial (did the infection originate in the facility) yes/no and follow up. The log identified 2 cellulitis, 1 vaginal infection, 2 pneumonia, 1 great toenail removal, and 3 UTI. No cultures were identified and 1 UTI was identified as “none”. Additionally, the log failed to identify any infectious symptoms not treated with an antibiotic. The facility Nursing Home Infection Control Log dated July 2026, identified the resident name, date, onset date, site, infection related diagnosis, culture yes/no, organism, antibiotic, isolation yes/no, nosocomial (did the infection originate in the facility) yes/no and follow up. The log identified 4 UTI, 1 g-tube infection, 1 eye infection, a leg infection, 1 lung infection, 2 cellulitis and 1 resident treated with an antibiotic with no other information provided. Additionally, the log failed to identify any infectious symptoms not treated with an antibiotic and failed to identify R1’s diarrheal symptoms on 7/25/26. During an interview on 7/28/26 at 1:58 p.m., the facility infection preventionist (IP)-A stated she was responsible for the facility’s education coordination and gathering surveillance data to report for IP during the QAPI meeting. Once per month, IP-A received the Nursing Home Infection Control Log from the director of nursing (DON), usually at the beginning of the following month. If something were to come up during the month, it would be discussed during the interdisciplinary team (IDT) meeting. IP-A also collected data for the Risk meeting as well, but it was basic information such as numbers of			F0880			09/02/2026

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F0880 SS = F	Continued from page 12 infections and the number of line days for the facility. During an interview on 7/30/26 at 2:51 p.m., the DON stated nursing was responsible for entering a nursing note and the DON would review the notes to add the infections to the Nursing Home Infection Control Log. Then, at the end of the month, she provided the log to IP-A to review the information. However, viral infections were not added to the log. The DON stated she used to try to keep track of everything, but she had so much on her plate she just wasn't able to get it all done. However, all signs/symptoms of infection should have been tracked to prevent the potential spread of infection. The facility policy Infection Surveillance revised 5/2025, identified infection prevention began with routine and ongoing surveillance to identify possible communicable diseases or infections before they could spread to other persons in the facility or have the potential to cause an outbreak. The policy directed the following: The unit charge nurses will identify residents with symptoms or identified infections and complete the Criteria for Infection Report Forms for the respective type of infection and report to the IP: UTI, respiratory tract infection; gastrointestinal tract infection; skin, soft tissue and mucosal infections. The IP will ensure data collection to complete a comprehensive monthly infection control log for the surveillance activities on: Site Pathogen Signs and symptoms Resident location Summary and analysis of number of residents and/or staff with infections Observations of staff adherence to policies and procedures.			F0880			09/02/2026

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F0880 SS = F	Continued from page 13 identification of outcomes that were unusual or unexpected that could potentially lead to patterns, trends or outbreaks. The IP or designee would be alerted to identify any necessary interventions in or to identify trends or clusters for action. The IP would keep an updated map of infections to identify any clusters or trends. Data obtained from process surveillance audits would be collected to analyze the compliance of staff with facility policies and procedures.			F0880			09/02/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to assess ability to independently activate the call light and provide a reasonable accommodation for 1 of 1 resident (R29), such as an adaptive call light, after staff became aware of ongoing difficulty using the standard call system, resulting in the potential for delayed access to assistance for toileting and other care needs. Findings include: R29's quarterly Minimum Data Set (MDS) dated 6/20/26, identified R29 had a moderate cognitive impairment and diagnoses that included chronic kidney disease, a pressure ulcer of the sacral region, atrial fibrillation (irregular heartbeat) and hypertension. R29 required set up/clean up assistance with eating and oral hygiene, substantial/maximal assistance with bathing, and was dependent on staff for all other care areas. R29's care plan revised 7/12/26, identified R29 had occasional urinary incontinence and preference for a bedpan related to impaired mobility. Staff were			F0558	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R29's ability to independently operate the call-light system will be formally assessed. The resident and representative will be included in determining an appropriate call system. An adaptive call device will be trialed/provided if indicated by the assessment and resident preference. The resident's care plan will be reviewed/updated to identify the appropriate call-light device and assistance needed. How the facility will identify other residents having the potential to be affected by the same The facility reviewed residents with impaired hand strength, dexterity, range of motion, cognition, vision, or other conditions that could interfere with use of a standard call light. Residents identified with potential difficulty will be assessed and adaptive call devices will be implemented as indicated. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. A call-light accessibility assessment process will be implemented for: • admission; • significant change in condition; • reports that a resident cannot operate the call light; and		09/02/2026

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F0558 SS = D	Continued from page 14 directed to Respond promptly to toileting requests and provide the bedpan according to resident preference whenever safely possible. Provide prompt incontinence care following episodes of urinary incontinence, monitor for constipation, urinary tract infection, and skin breakdown, educate regarding safe toileting options, and notify the provider of significant changes in bowel or bladder status. Keep call light in reach. During an interview on 7/29/26 at 10:48 a.m., R29 stated she could push her call button, and the staff didn't come for over two hours. Family member (FM)-A stated R29's understanding of time had changed, and two hours was an exaggeration, however, R29 had difficulty pushing the call light at times. R29 had believed the call light had been turned on and the call light did not. R29 and FM-A had not suggested a different type of call light that might be easier for R29 to use. "They just don't come. You can wait and wait. They just don't." R29's electronic medical record lacked any assessment for R29's call light ability. During an interview on 7/29/26 at 2:17 p.m., nursing assistant (NA)-A stated R29 complained that she had turned on her call light and staff do not answer probably every day. NA-A had reported this to nursing but there's been no changes. During an interview on 7/29/26 at approximately 3:00 p.m., the director of nursing (DON) stated R29 had complained of long call wait times, but after reviewing the call light logs, R29 had not turned on her call light. R29 was able to push the call light button and did not like a pancake call light (a flat, pressure-sensitive call light). However, R29 did not have a formal call light assessment, nor did the facility try a different type of adaptive call light for R29. A facility call light policy was requested but not received.			F0558	Continued from page 14 • recurring complaints that staff are not responding when electronic records do not show activation. Staff will be educated to report difficulty operating a call light to the licensed nurse for assessment rather than assuming the resident did not activate the system. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON/designee will audit 5 dependent/high-risk residents weekly for 4 weeks and monthly for 2 months to verify the call light is accessible and the resident can activate the device or has an appropriate alternative. Results will be reviewed through QAPI. The date each deficiency will be corrected. September 2, 2026		09/02/2026
F0605 SS = D	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 . . .			F0605	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Order was immediately placed on hold until further review could occur. R19's PRN antipsychotic order will be reviewed with the prescribing practitioner and consultant pharmacist. The order will be discontinued, revised, or reissued consistent with federal requirements,		09/02/2026

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F0605 SS = D	Continued from page 15 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. §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			F0605	Continued from page 15 including the 14-day limitation and practitioner evaluation requirements. Clinical indications and behavioral symptoms supporting any continued PRN use will be documented in the medical record and care plan. How the facility will identify other residents having the potential to be affected by the same Audit to ensure all psychotropic PRN orders have an end date of 14 days. The DON/designee reviewed all residents with PRN psychotropic medications, with specific attention to PRN antipsychotic medications, to verify: • a diagnosed clinical indication; • order duration; • required practitioner evaluation; • documentation supporting continued use; and • compliance with applicable 14-day requirements. Any identified discrepancies will be corrected with the prescribing practitioner. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. Policy updated to reflect that all PRN psychotropics are required to have an end date of 14 days. The psychotropic-medication review process will be revised so that PRN antipsychotic orders are flagged at entry and before expiration. Licensed nurses and applicable providers/pharmacy personnel will be educated that a new PRN antipsychotic order may not be renewed without practitioner evaluation. Pharmacy review will include identification of PRN antipsychotic orders approaching 14 days and notification to nursing and the prescriber. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON or designee will monitor all PRN psychotropic orders to ensure end date of 14 days has been		09/02/2026

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F0605 SS = D	Continued from page 16 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; §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.			F0605	Continued from page 16 entered and report to QAPI. The DON/designee will audit 100% of PRN antipsychotic orders weekly for 4 weeks and monthly for 2 months for indication, duration and practitioner evaluation/documentation. Results will be presented to QAPI. The date each deficiency will be corrected. September 2, 2026		09/02/2026

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F0605 SS = D	Continued from page 17 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure an as-needed (PRN) antipsychotic medication order was limited to 14 days and failed to ensure the resident was evaluated by the prescribing practitioner before the PRN antipsychotic medication was renewed. In addition, the facility failed to ensure there was adequate clinical justification for the use of the PRN antipsychotic medication when it was restarted at the request of the resident's family for 1 of 5 residents (R19) reviewed for unnecessary medications. Findings include; R19's quarterly Minimum Data Set (MDS) dated 5/29/26, identified R19 had moderately impaired cognition. and exhibited behaviors symptoms not directed at others such as rummaging, pacing, disrobing or disruptive sounds one to three days per week. R19 also displayed rejection of care and wandering four to six days per week. R19 had not exhibited physical or verbal symptoms toward others during the observation period. R19 had taken antipsychotic medications. Diagnoses included Parkinson's disease, Alzheimer's disease, dementia with agitation, and mild neurocognitive disorder with behavioral disturbances. R19's care plan with revision date 6/10/26, identified behavioral symptoms of verbal and physical behavioral symptoms directed toward others such as screaming, cursing and hitting others with a goal to accept assistance with activities of daily living (ADL) without threatening behaviors. Approaches included to avoid power struggles, maintain calm, slow approach and provide a comfortable private environment for care. R19 was seen by neurology and family hoped they could get her medications straightened out for her Parkinson's and dementia, so behaviors would not continue. R19's Physician Order Report(s) identified the following: 5/1/26 to 6/30/26, included olanzapine 2.5 mg by mouth as needed prn daily for severe agitation, with a start date 3/31/26, the end date was listed as open ended. 6/30/26 to 7/30/26, included olanzapine 2.5 milligrams (mg) by mouth as needed (prn) daily for severe agitation, with a start date 7/23/26, the end date was listed as open ended. R19's provider notes identified the following: Physician Order Report 5/1/26 to 6/30/26, listed			F0605			09/02/2026

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F0605 SS = D	Continued from page 18 several medication orders which included olanzapine 2.5 mg by mouth as needed prn daily for severe agitation, with a start date 3/31/26, the end date was listed as open ended. Physician Progress Note dated 4/11/26, identified R19 was seen by her primary care provider (PCP) and medications reviewed. Assessment and Plan identified psychiatry was managing R19's medications for her agitation with violent behaviors and R19 was on scheduled Seroquel (antipsychotic medication) daily as well as prn olanzapine daily as needed for agitation or violent behavior. The PCP identified R19's behaviors had improved with the drug regimen. Psychiatric provider note dated 4/13/26, identified R19 presented with ongoing improvement in agitation and psychosis on her current medication regimen and had not required prn olanzapine since her last visit one week prior. Psychiatric provider note dated 4/23/26, identified R19 had been stable and had not required any prn medications. Psychiatric provider notes dated 5/27/26, identified R19 had minimal behavioral incidents and had used prn olanzapine one time on 4/30/26 for agitation related to refusing care. R19 had not required the prn olanzapine since that episode and family reported R19 was doing well overall. Physician Progress Note dated 6/11/26, identified R19 was seen by her primary care provider (PCP) and medications reviewed. Plan identified psychiatry was managing R19's psychotropic medications including her olanzapine, which was on board as needed. R19's behavior had improved with no verbal or physical aggression recently. Psychiatric provider notes dated 6/12/26, identified R19's hallucinations had been well controlled with no recent auditory or visual hallucinations reported. Medications were reviewed, including olanzapine with notation the medication had not been used in nearly four weeks and was going to be discontinued due to the lack of use. Psychiatric provider notes dated 6/18/26, identified R19 had been stable over the past two months with minimal behavioral or psychological disturbances and her olanzapine was previously discontinued due nonuse. Psychiatric provider notes dated 7/16/26, identified			F0605			09/02/2026

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F0605 SS = D	Continued from page 19 R19 was being seen for follow up for medication management and agitation in Alzheimer's dementia. Staff had noted R19 was getting out more frequently with family. A behavioral concern had been noted that R19 had refused to return indoors on at least one occasion following an outing. Family requested prn olanzapine be restarted for agitation. R19 had not had anger outbursts similar to prior episodes, but family would like the medication available. The prn medication had been stopped due to it had not been utilized. The plan identified to add olanzapine 2.5 mg tablet prn for severe agitation, once daily as needed for 30 days. Physician Progress Note dated 7/22/26, identified R19 was seen by her primary care provider (PCP) and medications reviewed. Plan identified psychiatry was managing R19's psychotropic medications and to continue olanzapine 2.5 mg as needed. Review of R19's medical record from 4/11/26 through 7/22/26 identified R19 was seen by medical providers on 4/11/26, 4/13/26, 4/23/26, 5/27/26, 6/11/26, and 6/12/26. The medical record identified R19's PRN olanzapine remained available for use beyond 14 days. The medical record did not identify R19 was directly examined and evaluated by the prescribing practitioner every 14 days to determine whether a new PRN antipsychotic medication order remained appropriate. The PRN olanzapine was discontinued on 6/12/26 due to nonuse. Further, The medical record did not identify adequate clinical justification for restarting PRN olanzapine for severe agitation after the medication had been discontinued due to nonuse. The 7/16/26 psychiatric provider note identified R19 had not experienced anger outbursts similar to her previous episodes and identified the medication was restarted following the family's request to have the medication available. During interview on 7/30/26, at 10:45 a.m. the director of nursing (DON) stated R19 had prn olanzapine ordered 4/26/26 through 6/23/26, by her psychiatric provider. The psychiatric provider reviewed her medications and had chosen to keep continuing the prn medication when she did. The pharmacist had made the recommendation to the provider about the need to do a face-to-face evaluation with R19 for the continued use of the prn olanzapine, or it needed to be discontinued. The DON did not know why the physician had not done so. The facility's consultant pharmacist was not available; they did have a backup pharmacist that filled in for medication questions. During interview on 7/30/26, at 10:54 a.m. registered nurse (RN)-B stated there had been situations when R19 would refuse to get out of the car and go into the facility			F0605			09/02/2026

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F0605 SS = D	Continued from page 20 after outings with the family but not as severe as the behaviors had been when R19 was first admitted. The family was fearful if she did react that badly again at the end of these outings, there would be something to give R19 to calm her down. There should be more justification for the use of the prn medication, and the facility would request a better narrative from the prescriber. RN-B had reminded the prescriber there needed to be a fourteen-day assessment. An attempt to contact R19's psychiatric provider by telephone was made on 7/30/26, at 2:40 p.m. with message left. During telephone interview on 7/30/26, at 3:36 p.m. pharmacist (PH)-F stated she was not familiar with nursing home regulations in regard to prn psychotropic medications. The facility policy Psychotropic Medication and Monitoring dated 10/17/23, identified prn psychotropic medications would be prescribed on a prn basis to address acute or intermittent symptoms, or in an emergency. In order for a resident to have a prn order for a psychotropic medication, the physician must document the diagnosed specific condition and indication for the medication. An order may be extended beyond fourteen days if the physician believed it was appropriate to extend the order. The provider should document the rationale for the extended time period in the medical record and indicate the specific duration. Prn orders for antipsychotic medications were for fourteen days with no exceptions. If the provider wished to write a new order for a prn antipsychotic, the provider must first evaluate the resident to determine if the new order was appropriate and document the findings in the resident's medical record.			F0605			
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult			F0609	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R25's 6/7/26 incident will be reviewed under the facility's abuse/neglect reporting policy. Facility leadership reviewed the reporting determination and completed any required follow-up reporting/documentation that remained available to be completed. The resident's current status and care plan will be reviewed. How the facility will identify other residents having the potential to be affected by the same The Administrator/DON reviewed recent accidents and incidents involving injury to determine whether circumstances could constitute an allegation of abuse, neglect, mistreatment, exploitation, injury of unknown source, or misappropriation requiring reporting to the State Agency.		09/02/2026

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F0609 SS = D	Continued from page 21 protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to identify and report an alleged violation of neglect to the State Agency (SA) for 1 of 1 resident (R25) reviewed for accident reporting. R25 slipped and fell on a freshly mopped, wet floor after facility staff failed to place a wet-floor warning sign and sustained a head laceration that required six sutures at the emergency department. R25's annual Minimum Data Set (MDS) dated 4/21/26, identified R25 had intact cognition, was independent with activities of daily living (ADLs), transfers and ambulation. R25 had not experienced any falls since admission or the previous assessment. Diagnoses included repeated falls, dysthymic disorder, unspecified intracranial injury, osteoporosis, essential tremor, paroxysmal vertigo, gait and mobility abnormalities, weakness, urinary incontinence, seizures and disorientation. During interview on 7/27/26, at 6:49 p.m. R25 stated she had fallen in her room a few weeks prior, when she trying to go to the bathroom. The housekeeper had just mopped the floor, and she had slipped on the wet floor and fell. She hit the back of her head on the floor during the fall and had to go to the emergency room where she received six stitches to the back of her head. R25 stated a wet floor sign had not been placed, and she was not aware her floor was wet when she tried to ambulate to the bathroom. R25' The Patient/Resident Event Report Form dated 6/7/26, at 11:30 a.m. identified R25 had an unwitnessed fall in her room. The report identified R25 was coming out of the bathroom and the floor was wet and she slipped and hit the back of her head on the concrete floor. A one-to-two-centimeter laceration and egg like bruise was observed on the back of R25's head and she was sent to the			F0609	Continued from page 21 Any identified unreported event will be addressed according to applicable reporting requirements. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. Administrator, DON, nursing supervisors, and other staff involved in incident review will be educated regarding reporting timelines and the requirement to report an allegation when facts reasonably suggest neglect rather than waiting for completion of the internal investigation. The facility implemented a standardized incident-reportability checklist requiring documentation of: • whether abuse/neglect is alleged or suspected; • whether serious bodily injury occurred; • applicable reporting timeframe; • date/time reported; and • rationale when an incident is determined not reportable. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Administrator/designee will review 100% of incidents involving injury, environmental hazard, unexplained injury, or potential caregiver neglect weekly for 4 weeks and monthly for 2 months to verify appropriate reporting decisions and documentation. Findings will be reviewed through QAPI. The date each deficiency will be corrected. September 2, 2026		09/02/2026

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F0609 SS = D	Continued from page 22 emergency room to evaluate. Listed actions taken included assist of one in room and a physical therapy evaluation. The floor was confirmed to be wet. R25's CT Spine Cervical Without Contract Results dated 6/8/26, identified R25 had a CT of the brain and cervical spine was performed. There were no acute intracranial process and no acute fracture; however, the CT results did identify R25 did have a head laceration. No further hospital documentation was received from the facility. R25's progress note(s) identified the following: 6/7/26, R25 was found on her bedroom floor with a moderate amount of blood on the floor and the back of her head. R25 had stated she was up to use the restroom, but the floor had just been mopped and was slippery. R25 had slipped and fell and hit the posterior right side of her head. Area of head was cleansed and there was a one-to-two-centimeter laceration and a five-centimeter egg lump on the back of her head. R25 denied pain and pupils were equal and reactive to light. Range of motion and hand grasps were within normal range. R25 was sent to the emergency room for further assessment. 6/7/26, R25 returned from the hospital at 1:30 p.m. and had received 8 staples to the back of her head. 6/13/26, identified the staples were present and the wound was dry, intact and had no signs of infection. There was no report made to the SA.During an interview on 7/30/26, at 10:06 a.m., the director of nursing (DON) stated she began investigating R25's fall when she was notified of the incident. At that time, the DON had not been aware the floor was wet when R25 fell. Because of staff scheduling, it took a couple of days to identify and interview the staff who had been working at the time of the fall. The DON stated it also took time to identify the housekeeper involved because housekeeping staff worked campus-wide and were not assigned only to the nursing home. During the investigation, the DON met with staff who had been working that day and verified the floor was wet at the time of R25's fall. The housekeeper had recently been in R25's room and reported she had reminded R25 the floor was wet; however, a wet floor sign had not been placed. The DON stated she spoke with the housekeeping supervisor (HS)-C, who then spoke directly with the housekeeper and provided education. The DON stated the facility's fall committee met every Wednesday. The committee discussed R25's			F0609			09/02/2026

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F0609 SS = D	Continued from page 23 fall, including what could have been done differently. The DON recalled the team also discussed whether the incident was reportable but could not remember why the team ultimately determined it was not a reportable incident. The DON stated that in the past she had reported many incidents and had subsequently been questioned about why an incident was reported or whether it was actually reportable. The DON was unable to provide any supporting documentation regarding the discussion and education. The facility policy Abuse, Neglect, Mistreatment and Misappropriation of Resident Property with review date 6/25/24, identified if there was caregiver neglect (i.e., the care plan not being followed that resulted in a resident injury), a report must be made to the Minnesota Department of Health within 24 hours of the initial findings.			F0609			
F0657 SS = D	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			F0657	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R15's comprehensive care plan will be reviewed and revised to accurately identify the resident's current level of independence and assistance required for toileting, transfers, and ambulation. Conflicting or outdated interventions will be removed or clarified. How the facility will identify other residents having the potential to be affected by the same The DON/designee reviewed current residents with recent therapy changes, significant functional changes, or MDS updates to verify corresponding care-plan interventions accurately reflect current status. Identified discrepancies will be corrected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. The facility reinforced a process requiring nursing/therapy changes affecting ADLs, transfers, mobility, toileting, fall interventions, or other care needs to be communicated to the MDS coordinator/designee and incorporated into the care plan. The IDT will be educated regarding timely removal or revision of outdated and conflicting interventions. How the facility will monitor its corrective actions to		09/02/2026

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F0657 SS = D	Continued from page 24 comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to revise the comprehensive care plan to accurately reflect that a resident was independent with toileting, transfers, and ambulation for 1 of 4 residents (R15) whose care plans were reviewed. Findings Include: R15's quarterly Minimum Data Set (MDS) dated 5/4/26, identified moderate cognitive impairment. R15 needed supervision to touch assist with toileting, transfers, and walking. Diagnosis included Alzheimer's disease-late onset. No falls from the last assessment (3 months). R15's care plan dated 5/21/26, identified R15 had a history of falls An intervention dated 5/21/26, identified per therapy R15 was observed with an unsteady balance and was not able to stabilize without human assistance for on and off the toilet and surface-to-surface transfers; independent with standing, walking, turning around while walking. A second intervention dated 5/21/26, identified per therapy R15 was observed with unsteady balance but able to stabilize without human assistance for on and off the toilet and surface-to-surface transfers, standing, walking, turning around while walking. During observations on 7/29/26 and 7/30/26, R15 was observed to stand up, ambulate, use the bathroom and go to the dining room without assistance, and was stable on their feet. During an interview on 7/30/26 at 10:21 a.m., nursing assistant (NA)-G stated R15 was vastly independent and only needed slight help getting up and washed up in the morning. Otherwise, he was independent with all transfers, toileting, and ambulation. During an interview on 7/30/26 at 11:16 a.m., registered nurse (RN)-B, a clinical care coordinator, stated care plans are reviewed regularly during inter-disciplinary team meetings (IDT). R15's care plan should only have the second intervention due to R15 being identified as independent by therapy. During an interview on 7/30/26 at 11:20 a.m., the director of nursing (DON) stated it should have been updated to identify the R15's current status so all staff are aware of the care R15 needs. The RN who normally addresses care plans was not available and noted there was a			F0657	Continued from page 24 ensure that the deficient practice is being corrected and will not recur. The DON/designee will audit 5 care plans weekly for 4 weeks and monthly for 2 months, comparing current MDS/therapy/nursing documentation with active care-plan interventions. Results will be reported to QAPI. The date each deficiency will be corrected. September 2, 2026		09/02/2026

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F0657 SS = D	Continued from page 25 mistake with updating R15's care plan. It should have stated R15 was independent. A care plan policy was requested, but none received.			F0657			09/02/2026
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.			F0676	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R13's toileting needs, bowel pattern, call-light access, transfer assistance and response needs will be reassessed. The care plan will be reviewed and revised as indicated. Staff will be educated regarding prompt response to R13's toileting requests and escalation to licensed nursing when assistance cannot be provided promptly. How the facility will identify other residents having the potential to be affected by the same The facility reviewed call-light response data and residents requiring assistance with toileting, particularly residents who are continent and dependent on staff for transfers. Residents demonstrating prolonged response times or unmet toileting needs will be reassessed and care plans/interventions adjusted as indicated. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. Nursing staff will be educated regarding the facility's call-light response expectations and the need to prioritize toileting requests. A process will be implemented for call lights exceeding the facility response-time expectation to be escalated to available nursing personnel. Staffing assignments and peak-demand periods will be reviewed to identify opportunities for additional coverage or redistribution of staff duties. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON/designee will review a sample of call-light response times on each shift 5 days per week for 4 weeks, then weekly for 2 months, including residents dependent upon staff for toileting. Trends and corrective actions will be reviewed through QAPI.		09/02/2026

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F0676 SS = D	Continued from page 26 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide timely toileting assistance for 1 of 1 resident (R13) reviewed who had complaints of not receiving timely toileting assistance. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/22/26, identified R13 was cognitively intact and needed substantial/maximal assistance for transfers and toileting. R13 was continent of bowel and bladder. R13's diagnoses included stroke and irritable bowel syndrome (a condition which affects the large intestine) with diarrhea. R13's care plan dated 7/9/26 identified R13 needed assistance with toileting related to impaired mobility following a stroke. The care plan identified staff would respond promptly to requests for toileting assistance, provide one-person pivot transfers as indicated, and assist with toileting hygiene. R13's call light log from 7/10/26-7/23/26, identified four times R13 had waited from 24-35 minutes prior to their call light being answered. During an interview on 7/27/26 at 6:39 p.m., R13 stated I sometimes had to wait 30 minutes for assistance to the bathroom. Due to having to wait I soiled myself numerous times and became embarrassed. During an interview on 7/30/26 at 10:53 a.m., nursing assistant (NA)-B stated R13 had soiled their brief after having to wait more than 30 minutes. When we get busy, residents may have to wait longer than 30 minutes to getting assistance. During an interview on 7/30/26 at 11:50 a.m., registered nurse (RN)-A stated at times they do not have enough staff to help all the residents quickly. Nursing will assist the NAs in answering call lights at this time. I was not aware if a resident waited longer than 30 minutes, but they should not have waited that long. During an interview on 7/30/26 at 12:00 p.m., the director of nursing (DON) stated the facility policy is to have all call lights answered within 10 minutes and that is the expectation for staff. It would be unacceptable for residents to have to wait longer than 20 minutes before receiving help. The facility's undated Use of Call Light policy			F0676	Continued from page 26 The date each deficiency will be corrected. September 2, 2026		09/02/2026

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F0676 SS = D	Continued from page 27 identified all call lights are to be answered promptly.			F0676			09/02/2026
F0677 SS = D	The facility's undated policy Activities of Daily Living (ADL) identified several purposes which included to provide assistance to residents as necessary. ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence care for 1 of 1 resident (R9) reviewed for activities of daily living and who were dependent on staff for their care. Findings include: R9's annual Minimum Data Set (MDS) dated 4/17/26, identified R9 had severe cognitive impairment and required maximal assistance with dressing, grooming and toileting hygiene. R9 was dependent with transfers and bed mobility and was unable to ambulate. R9 did not have behaviors of rejection of care. Diagnoses included Alzheimer's disease, abnormal gait and mobility, history of transient ischemic attack (TIA) and stroke, heart disease and dementia. R9's care plan date with revision date 4/30/26, identified an activity of daily living (ADLs) functional status with a goal R9 would not deteriorate as evidenced by maintaining her ability to be independent with bed mobility, transfers, walking and eating after setup. Approaches were listed and included R9's usual performance was substantial assistance with toileting hygiene, bathing, and dressing. During observation on 7/29/26, at 12:07 p.m. nursing assistant (NA)-C entered R9's room and notified R9 he would assist her up to go to lunch. NA-C put on disposable gloves and assisted resident to sit on the edge of the bed. NA-C placed a gait belt around R9's waist and assisted her into her wheelchair using a stand and pivot to transfer. When R9 stood up, her jeans were visibly wet along each outer buttock and hip area. After assisting R9 into her wheelchair, NA-C removed the gait belt and his gloves and wheeled her out to the hall. When asked if R9 used the toilet prior to meals, NA-C stated R9 did not and was check and change only, as R9 was incontinent. NA-C assisted R9 back into bed. NA-C			F0677	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R9 received immediate incontinence care when the condition was identified. R9's current continence status and care needs will be reassessed and the care plan reviewed. Staff assigned to R9 will be educated regarding scheduled checks, prompt incontinence care and maintaining the resident clean and dry. How the facility will identify other residents having the potential to be affected by the same The DON/designee identified residents dependent on staff for continence care and verified that their care plans and CNA assignment tools/Resident care slip, accurately reflect required frequency of checks and care. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. Nursing assistants and licensed nurses will be re-educated regarding timely incontinence checks and care for residents unable to independently toilet or communicate their needs. CNA assignment tools/Resident care slip will clearly identify residents requiring scheduled continence checks. Licensed nurses will provide oversight to ensure residents are checked during extended periods in bed and before meals/activities as appropriate How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON/designee will complete 5 continence-care observations/audits per week for 4 weeks and monthly for 2 months for residents dependent on staff. Findings will be reviewed through QAPI.		09/02/2026

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F0677 SS = D	Continued from page 28 confirmed R9's jeans were wet and put on gloves and removed her pants. R9's brief was saturated and R9 had been incontinent of bowel. NA-C removed the soiled brief and washed R9's peri area with disposable wipes. NA-C changed his gloves and put on a clean brief and clean pants. NA-C transferred R9 back into her wheelchair and assisted her to the dining room for her lunch meal. During interview on 7/29/26, at 12:10 p.m. NA-C stated he had not been in to check or change R9 since she was assisted to lie down after breakfast. NA-C stated he had not turned or checked for incontinence before transferring R9 to her wheelchair to go to lunch. NA-C thanked surveyor for noting R9 jeans were wet as he would not have liked for her to be in a soiled brief and he had forgotten to check her. During interview on 7/29/26, at 2:12 p.m. registered nurse (RN)-A stated R9 was incontinent of both bowel and bladder and should be checked every two hours and changed when needed. During interview on 7/30/26, at 10:30 a.m. the director of nursing (DON) stated R9 had been fluctuating back and forth with her care needs but with the hot weather it was especially important to push fluids and keep residents clean and dry. The DON knew residents were not left in soiled briefs and felt the staff was too nervous about being watched and went to quickly, anxious about getting the resident to the dining room and forgot steps. The facility's undated policy Activities of Daily Living (ADL) identified several purposes which included to provide assistance to residents as necessary.			F0677	Continued from page 28 The date each deficiency will be corrected. September 2, 2026		09/02/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			F0686	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R9's skin will be assessed and the resident's current risk for pressure injury and ability to independently reposition will be reviewed. Staff will be educated regarding R9's current repositioning needs and the care plan updated accordingly. How the facility will identify other residents having the potential to be affected by the same The DON/designee will review residents identified as requiring staff-assisted repositioning or heel offloading to verify care plans, CNA assignment tools/Resident care slip and current clinical needs are consistent. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur.		09/02/2026

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F0686 SS = D	Continued from page 29 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to reposition a resident in accordance with the resident's established every two-hour turn and reposition schedule for 1 of 1 resident (R9) reviewed for pressure ulcer prevention and was at risk for developing pressure ulcers. Findings include; R9's annual Minimum Data Set (MDS) dated 4/17/26, identified R9 had severe cognitive impairment and required maximal assistance with dressing, grooming and toileting hygiene. R9 was dependent with transfers and bed mobility and was unable to ambulate. R9 did not have behaviors of rejection of care. Diagnoses included Alzheimer's disease, abnormal gait and mobility, history of transient ischemic attack (TIA) and stroke and dementia. R9's care plan dated 4/30/26, identified an activity of daily living (ADLs) functional status with a goal R9 would not deteriorate as evidenced by maintaining her ability to be independent with bed mobility, transfers, walking and eating after setup. Approaches were listed and included R9's usual performance was substantial assistance with toileting hygiene, bathing, dressing, partial assist with eating, and dependent with all other functional abilities. R9 was unable to ambulate and was switched to a two person stand and pivot transfer. The care plan also identified a risk for pressure ulcers with a goal R9's skin would remain intact. Approaches included staff to observe skin daily with care and nursing to complete a head-to-toe assessment weekly. R9 had a standard pressure reduction mattress. R9's Progress Note dated 7/26/26, identified R9 continued to be assist of two with transfer and assist of one with ADLs. R9 had a turn and reposition schedule when in bed and heels were to be off-loaded with a pillow. During continuous observation on 7/29/26, from 9:30 a.m. to 12:06 p.m. R9 was observed lying on her back with her arms extended down on either side. R9 was fully dressed and covered with a pink quilt. R9's bed was positioned in its lowest position, the lights to the room were off and the room was quiet. The door to her room was wide open. R9 was observed sleeping during the observation period and did not move on their own. No nursing staff entered the room during the observation period to offer repositioning.			F0686	Continued from page 29 The DON or designee will educate staff and develop a monitoring system to ensure staff reposition residents who require assistance in a timely manner. A standardized process will be implemented to communicate residents requiring turn/reposition assistance. Nursing assistants and licensed nurses will be educated regarding: • required repositioning intervals; every 2-3 hours or per the resident's indivudalized plan of care. • reassessment when a resident's functional ability fluctuates; and • escalation when the plan of care is no longer clinically appropriate. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON/designee will audit 5 residents requiring assisted repositioning weekly for 4 weeks and monthly for 2 months, including direct observation and documentation review. Results will be reported through QAPI. The date each deficiency will be corrected. September 2, 2026		09/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245247		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
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F0686 SS = D	Continued from page 30 On 7/29/26, at 12:07 p.m. nursing assistant (NA)-C entered R9's room, put on gloves, and explained to R9 he was there to get her up for lunch. NA-C sat R9 on edge of bed and placed a gait belt around her waist. NA-C pivot transferred R9 to her wheelchair. NA-C stated sometimes R9 was able to turn herself, unless she was tired, and then she needed help. NA-C stated he had not been in R9's room since he assisted her to lie down after breakfast. NA-C stated R9 did not currently have any open skin areas and could not identify if R9 should have been repositioned after two hours lying in bed, as he thought she was able to do so herself. During interview on 7/29/26, at 2:12 p.m. registered nurse (RN)-A stated the nursing assistants had a list of residents that required turning and repositioning every two hours on their clipboard. RN-A stated R9 was on the turn and reposition schedule, which included all residents that could not reposition themselves and all the residents on the list were to be repositioned every two hours. When interviewed on 7/30/26, at 10:30 a.m. the director of nursing (DON) stated R9's functional ability had been fluctuating back and forth. It was communicated during shift report and huddle when her care needs had increased. She was on a turn and reposition scheduled and the DON felt staff had not performed due to being nervous over being watched during survey. The facility's undated policy Activities of Daily living identified staff would provide assistance to residents as necessary.			F0686			09/02/2026
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive assessment was completed related to a diagnosis of Post Traumatic Stress Disorder (PTSD) to identify			F0699	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R1 will receive a trauma-informed care assessment addressing known trauma history, preferences and potential triggers. The care plan will be updated to include the PTSD diagnosis and individualized approaches, including preferred communication and staff approach. How the facility will identify other residents having the potential to be affected by the same Social Services/designee reviewed residents with diagnoses or documented histories indicating PTSD, trauma, abuse or other trauma-related concerns to verify an individualized trauma assessment and corresponding care-plan interventions will be completed.		09/02/2026

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F0699 SS = D	Continued from page 31 and mitigate potential triggers for 1 of 2 residents (R1) reviewed for trauma-informed care. Findings include: R1’s Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/29/25, identified R1 opened up about her history of abuse from her past boyfriends/husbands. This was confirmed to be true. R1 discussed how it went on for many years. She explained that she has dyslexia (lifelong learning difference that affects how the brain processes written and spoken language), and her family often saw her as being less than due to her learning disability. She started experiencing a lot of emotional abuse from her own parents. She stated she had gone to counseling for this, and it helped her learning to see her self-worth and be more assertive. She also stated wanting to get in contact with a previous friend from her childhood who currently lives in Mexico City. She stated things have been going well for her and she had no other concerns. R1’s CAM/PHQ-2 to 9/PHQ-9-OV/Trauma observation dated 5/18/26, identified the trauma symptoms and triggers were not completed. R1’s quarterly Minimum Data Set (MDS) dated 5/28/26, identified R1 had a moderate cognitive impairment and diagnoses that included PTSD. R1’s care plan revised 5/30/26, failed to identify R1’s diagnosis of PTSD and/or interventions to address known triggers for R1. R1’s nursing note dated 7/25/26 at 5:34 p.m., identified R1 refused to eat breakfast, said she was not hungry. Did take 240 milliliter (ml) chocolate ensure (nutritional shake) with her medications. R1 said she had been sick with diarrhea. Writer told R1 that she should let nurse/staff know if she gets diarrhea again so R1 could get medicine for it. R1 answered “no one cares about me”. Writer told R1 she needed to be aware of what was going on with R1 or if R1 needed anything. A lunch tray was delivered to R1’s room since R1 refused to go to the dining room for lunch. R1 had been eating chocolates and snacks in her room. Writer went to R1’s room at supper time to encourage her to eat supper in the dining room. R1 asked “why?” Writer told R1 she had been laying down in her bed all day and if she could at least eat supper in the dining room. R1 may not feel good if she didn’t get up at all. R1 then agreed and put on socks and shoes, but before entering dining room R1 stated she did not			F0699	Continued from page 31 What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. Social Services and interdisciplinary staff will be educated that trauma assessment/care-plan review is required when trauma history or a PTSD diagnosis is newly identified and should not be deferred solely until the next annual assessment. A trigger will be added to the care-planning process requiring review after a new PTSD diagnosis or newly identified trauma history. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Social Services/designee will audit 100% of residents with identified PTSD/trauma history monthly for 3 months to verify individualized assessment and care planning. Results will be reviewed through QAPI. The date each deficiency will be corrected. September 2, 2026		09/02/2026

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F0699 SS = D	Continued from page 32 want to be told what to do. On 7/27/26 at 6:32 p.m., R1 was sitting in her room with her door shut. R1 stated she had a history of PTSD because she had been abused by her spouse and a boyfriend in her past. R1 stated she liked to stay in her room and preferred when staff knocked on the door and introduced themselves. R1 also preferred when staff suggested things to her, to go to the dining room for supper for example but did not like when staff told R1 what to do. "I don't like being bossed." During an interview on 7/28/26 at 2:36 p.m., nursing assistant (NA)-E and NA-F stated R1 liked to keep to herself. R1 likes to stay in her room with the door shut and R1 could be selective with staff as well. R1 could be very upfront and tell staff, "I don't want you in my room." NA-F stated R1 did have a history of abuse, but NA-F did not know what R1's triggers were. NA-E stated it was how staff approached R1 that mattered and, for some unknown reason, R1 would get "put off" by a staff member. During an interview on 7/28/26 at 3:33 p.m., registered nurse (RN)-A stated she worked the weekend on R1's hallway. It was either Saturday or Sunday and RN-A brought R1 her morning meds and asked R1 if she was going to the dining room for her breakfast meal. R1 didn't like to come out of her room, but we encourage her to. R1 stated she had been sick the whole day prior so I asked if R1 was throwing up or if she had diarrhea. RN-A explained RN-A might be able to give R1 medicine that might make R1 feel better. R1 was ok with that and wanted to stay in her room. RN-A didn't check on R1 at lunch, but another staff did and they brought R1 a tray because R1 didn't want to come out of her room. So around 5 or so, RN-A checked on R1 and asked how R1 was feeling. R1 said she had had diarrhea one time that day. RN-A asked if R1 was going to go to the dining room for supper. "Why? Why do you keep asking that?" RN-A explained R1 had been in her room all day and maybe getting out would make R1 feel better. It was calm and R1 put on her gripper socks and went to the dining room. RN-A and the other cart nurse then parked our carts down at the dining room. R1 often has a serious face expression but says things when R1 was actually joking so at first that's what RN-A thought was happening but R1 said she didn't want to be pestered anymore. Then next day during report, it was reported R1 no longer wanted RN-A in her room. During an interview on 7/30/26 at 12:04 p.m., the			F0699			09/02/2026

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F0699 SS = D	Continued from page 33 director of nursing (DON) stated R1's PTSD diagnosis was fairly new for R1 and had been seeing a mental health provider for that. However, the facility social work designee (SWD) was responsible for conducting the trauma informed care assessment and to care plan those things. During an interview on 7/30/26 at 12:05 p.m., SWD-A stated the trauma informed care assessments were conducted annually and R1 did not have a PTSD when she was admitted to the facility on 11/17/25. Because of this, SWD-A did not complete the trauma symptoms and triggers section of the CAM/PHQ-2 to 9/PHQ-9-OV/Trauma observation for R1 on 5/18/26 because it had not been a year. SWD-A stated, because R1 had been diagnosed with PTSD, the section should have been completed. A trauma informed care facility policy was requested but not received.			F0699			09/02/2026
F0770 SS = D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to obtain laboratory services as ordered for 1 of 1 resident (R9) reviewed for laboratory services when staff failed to arrange a white blood count (WBC) laboratory draw ordered for 7/10/26 following R9's return from the emergency department (ED). Findings include: R9's annual Minimum Data Set (MDS) dated 4/17/26, identified R9 had severe cognitive impairment and required maximal assistance with activities of daily living (ADLs). Diagnoses included Alzheimer's disease, history of transient ischemic attack (TIA) and stroke, heart disease and dementia. R9's care plan date dated 4/30/26, identified an			F0770	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R9's missed WBC order was identified, the provider notified, and laboratory testing was obtained pursuant to subsequent provider orders. R9's condition and laboratory follow-up will be reviewed for any adverse outcome and reported to Risk Management for follow-up accordingly. How the facility will identify other residents having the potential to be affected by the same The DON/designee reviewed recent hospital, emergency department and clinic return documentation for residents to verify all laboratory and diagnostic orders will be entered, scheduled and completed. Any missed or outstanding orders will be immediately communicated to the provider and completed as appropriate. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. The return-from-appointment/ED/hospital process will be revised to require: 1. review of all discharge/AVS pages by the receiving licensed nurse;		09/02/2026

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F0770 SS = D	Continued from page 34 alteration in health care status related to dementia, unstable gait, hypertension, chronic lymphocytic leukemia, osteoarthritis and history of TIA. A goal was listed to have vital signs in acceptable range. have pain controlled to mild range and have ordered labs in acceptable range. R9's ED Provider Notes dated 7/9/26, identified R9's plan of care was to return to the facility and to recheck R9s white blood count (WBC) the next day (7/10/26). R9's progress notes identified the following: 7/13/26, identified the after-visit summary (AVS) from R9's ED visit on 7/9/26, had been reviewed. Instructions on the AVS included to check a WBC on 7/10/26. When telephoned, the laboratory department indicated they had not performed a lab draw for R9 on 7/10/26. R9's primary care provider (PCP) was notified. 7/15/26, identified R9's PCP had responded to the facility's update with orders to draw a complete blood count with differential on 7/13/26 and 7/14/26. When interviewed on 7/29/26, at 2:12 p.m. registered nurse (RN)-A stated the charge nurse working on the resident's unit was responsible for checking orders when a resident returned from an appointment, hospital or emergency department. That nurse was also responsible to follow up if any changes or new orders were received. When completed the orders were to be rechecked by another nurse. During interview on 7/30/26, at 11:52 a.m. RN-B stated the nurse that had reviewed R9's AVS from her ED visit had missed the orders for the lab work. RN-B reviewed the orders and noticed the orders had not been called into the lab. RN-B placed the order with lab and notified the PCP of the error. The lab work was completed the next day after the error was discovered. A policy on physician orders was requested; however, none were received.			F0770	Continued from page 34 2. entry of all new orders; 3. a second-nurse verification of orders; and 4. confirmation that time-sensitive laboratory orders have been communicated to the laboratory and scheduled. Licensed nurses will be educated regarding the revised process How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON/designee will audit 100% of residents returning from an ED/hospital/clinic with new orders for 4 weeks, then 5 records monthly for 2 months to verify orders will be accurately transcribed and completed. Findings will be reported to QAPI. The date each deficiency will be corrected. September 2, 2026		09/02/2026
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention			F0881	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R9's recent antibiotic courses and clinical documentation will be reviewed by nursing, the Infection Preventionist, provider and/or pharmacist		09/02/2026

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F0881 SS = D	Continued from page 35 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement its antibiotic stewardship protocols for the assessment and monitoring of antibiotic use for 1 of 2 residents (R9) reviewed for antibiotic use. R9 received repeated courses of antibiotics for suspected urinary tract infections (UTIs); however, the facility failed to use its established UTI assessment process and failed to complete, and document required 72-hour antibiotic reassessments to evaluate the continued need, duration, and selection of antibiotic therapy. Findings include: R9's annual Minimum Data Set (MDS) dated 4/17/26, identified R9 had severe cognitive impairment and required maximal assistance with dressing, grooming and toileting hygiene. R9 was frequently incontinent of bowel and bladder. R9 did not have behaviors of rejection of care. Diagnoses included Alzheimer's disease, abnormal gait and mobility, history of transient ischemic attack (TIA) and stroke, heart disease and dementia. R9's care plan dated 4/30/26, identified an activity of daily living (ADLs) functional status with a goal R9 would not deteriorate as evidenced by maintaining her ability to be independent with bed mobility, transfers, walking and eating after setup. Approaches were listed and included R9's usual performance was substantial assistance with toileting hygiene, bathing, dressing, partial assist with eating, and dependent with all other functional abilities. R9 was frequently incontinent of bowel and bladder and required assistance with peri care. R9's Physician Order Report dated 6/29/26 to 7/29/26, identified several medications, including cephalexin 500 milligrams (MG) three times per day 7/10/26 to 7/16/26. Cephalexin was again ordered 500 mg two times per day 7/21/26 to 7/29/26. R9's Progress Notes identified the following: 7/9/26, R9 was lethargic and had a temp of 99. and elevated pulse of 113. Rhonchi (rattling) was noted			F0881	Continued from page 35 as appropriate. The facility will verify current treatment will be complete and evaluated whether additional follow-up will be clinically indicated. How the facility will identify other residents having the potential to be affected by the same The Infection Preventionist/DON/designee reviewed residents who had received antibiotics during the prior 30 days to verify: • clinical indication; • applicable infection assessment/SBAR documentation; • culture/laboratory review as ordered; • 72-hour antibiotic time-out/reassessment; and • documentation of continued need, duration and selection. Missing reassessments or documentation will be addressed prospectively as applicable. What measures will be put into place, or systemic changes made, to ensure that the deficient practice not recur. The antibiotic stewardship process will be revised to ensure that initiation of an antibiotic automatically generates a 72-hour reassessment reminder. Licensed nursing staff will be educated regarding: • use of the facility's UTI SBAR/assessment tool when indicated; • Loeb criteria as incorporated into facility policy; • obtaining/monitoring cultures when ordered; • documentation of provider communication; and • completion of the 72-hour antibiotic time-out. The consultant pharmacist/IP/DON will have clearly assigned roles for antibiotic stewardship review. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.		09/02/2026

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F0881 SS = D	Continued from page 36 throughout lungs. R9 had been seen in the emergency department (ED) and returned with a diagnosis which included acute cystitis. A new order was received for cephalexin 500 mg three times per day for seven days. 7/17/26, R19 had completed antibiotic treatment with no complaints of pain or discomfort. She was noted to have bilateral edema (swelling) in her lower extremities, and her primary care provider (PCP) was updated. 7/20/26, R19 returned from a clinic appointment and Rocephin 1 gram had been administered intramuscularly (IM) at the appointment. New orders were received for Nitrofurantoin 100 mg two times per day for cystitis/urinary tract infection. 7/21/26, R19's antibiotic was changed from Nitrofurantoin to cephalexin due to resident required medications to be crushed and unable to crush Nitrofurantoin. 7/28/26, R19 completed her last dose of cephalexin and denied pain or burning. R19's lab results were reviewed 6/8/26 through and identified the following: 6/8/26, a urinalysis was obtained and cephalexin 500 mg two times per day for five days was ordered. A urine culture was in process, however R19's medical record lacked the results of the culture. 7/13/26, identified R19 had Escherichia coli (e. coli, a bacteria) was present in her urine noted from the urinalysis obtained 7/9/26, and was sensitive to the cephalexin antibiotic treatment that was ordered. R9's medical record was reviewed from 6/1/26 through 7/28/26, lacked any further urinalysis or culture results, despite having received three courses of antibiotic treatment during the time frame. During interview on 7/30/26, at 10:30 a.m. the director of nursing (DON) stated the facility's consultant pharmacist was in charge of the facility's antibiotic stewardship program, however, was not available during survey and could not be reached via phone. The DON stated she had recently provided education to the facility staff on ways to prevent resident urinary tract infections, such as increasing fluids and frequent peri care and assistance with toileting. R19 was declining in health and did not drink a lot of fluids. The facility had recently			F0881	Continued from page 36 The Infection Preventionist/designee will audit 100% of newly initiated systemic antibiotic courses weekly for 4 weeks and monthly for 2 months for required assessment and 72-hour reassessment documentation. Antibiotic-use data and audit findings will be reported through QAPI. The date each deficiency will be corrected. September 2, 2026		09/02/2026

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F0881 SS = D	Continued from page 37 increased R19's fluids with meals and throughout the day and educated the staff on the new interventions. The facility used Situation, Background, Assessment and Recommendation (SBAR) forms specific for urinary tract infections (UTI) to communicate with resident's primary care providers. The UTI SBAR required the nurse to note the resident vital signs, and if symptoms of pain or burning with urination, temperature, or two or more symptoms such as urgency, blood in urine, incontinence of frequency was noted. The provider could respond with suggested orders as indicated on the bottom of the form. The DON was not able to provide the SBAR communication forms that were communicated the R19's PCP. The DON stated the staff do try to push fluids first for a suspected UTI, but they also wanted to notify the physician quickly because they had some residents that would show delayed symptoms and were very sick by the time they demonstrated symptoms. When interviewed on 7/30/26, at 11:52 a.m. registered nurse (RN)-B stated she had accompanied R9 to her provider appointment on 7/20/26, when she was given an injection of Rocephin and an antibiotic had been ordered. The provider did not feel more labs were needed and did not want to obtain a urinalysis or culture. The physician felt R9 still had cystitis and so just treated her with the Rocephin and oral Nitrofurantoin which then was changed to cephalexin. The consultant pharmacist did the facility antibiotic stewardship. Typically, when staff suspected a resident had a UTI, they pushed fluids, monitored, noted the urine, but it was an informal process. The SBAR was just to notify the provider of the resident's symptoms at the time of notification and was not a formal three-day type of process to ensure the staff have monitored and tracked symptoms before physician contact. The facility policy Antibiotic Stewardship with revision date 5/25, identified patients who needed antimicrobial therapy would get optimal drug selection, dose, duration and route to maximize patient outcomes, minimize side effects and decrease the emergence of resistance. Providers would utilize the Loeb criteria when considering the initiation of antibiotics. Consistent with the criteria, the UTI SBAR form would be used for all residents suspected of having a UTI. At 72 hours after antibiotic initiation the resident would be reassessed for consideration of antibiotic need, duration, selection and escalation potential. Laboratory testing results, response to therapy, resident condition and facility needs would be considered. Completion of antibiotic time-out must be recorded in the resident			F0881			09/02/2026

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NAME OF PROVIDER OR SUPPLIER KITTSO N HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH AVE , HALLOCK, Minnesota, 56728			
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F0881 SS = D	Continued from page 38 record. The facility would monitor antibiotic use, stewardship actions, and outcomes related to antibiotics in order to guide practice change and impact.			F0881			09/02/2026

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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 7/27/26 through 7/30/26, a 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 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. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal			20000			08/22/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
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20000	Continued from page 1 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 surveyors 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 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			08/22/2026
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.			20570	Corrected		09/02/2026

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20570	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to revise the comprehensive care plan to accurately reflect that a resident was independent with toileting, transfers, and ambulation for 1 of 4 residents (R15) whose care plans were reviewed. Findings Include: R15's quarterly Minimum Data Set (MDS) dated 5/4/26, identified moderate cognitive impairment. R15 needed supervision to touch assist with toileting, transfers, and walking. Diagnosis included Alzheimer's disease-late onset. No falls from the last assessment (3 months). R15's care plan dated 5/21/26, identified R15 had a history of falls An intervention dated 5/21/26, identified per therapy R15 was observed with an unsteady balance and was not able to stabilize without human assistance for on and off the toilet and surface-to-surface transfers; independent with standing, walking, turning around while walking. A second intervention dated 5/21/26, identified per therapy R15 was observed with unsteady balance but able to stabilize without human assistance for on and off the toilet and surface-to-surface transfers, standing, walking, turning around while walking. During observations on 7/29/26 and 7/30/26, R15 was observed to stand up, ambulate, use the bathroom and go to the dining room without assistance, and was stable on their feet. During an interview on 7/30/26 at 10:21 a.m., nursing assistant (NA)-G stated R15 was vastly independent and only needed slight help getting up and washed up in the morning. Otherwise, he was independent with all transfers, toileting, and ambulation. During an interview on 7/30/26 at 11:16 a.m., registered nurse (RN)-B, a clinical care coordinator, stated care plans are reviewed regularly during inter-disciplinary team meetings (IDT). R15's care plan should only have the second intervention due to R15 being identified as independent by therapy. During an interview on 7/30/26 at 11:20 a.m., the director of nursing (DON) stated it should have been updated to identify the R15's current status so all staff are aware of the care R15 needs. The RN who normally addresses care plans was not available and noted there was a			20570			09/02/2026

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20570	Continued from page 3 mistake with updating R15's care plan. It should have stated R15 was independent. A care plan policy was requested, but none received. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures and ensuring each individual resident's care plan was updated to reflect current resident needs. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete care plans. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20570			09/02/2026	
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a safe environment by ensuring appropriate precautions remained in place while a freshly mopped floor was wet for 1 of 2 residents (R25) reviewed for falls and failed to provide transfer assistance in accordance with the resident's care-planned interventions for 1 of 1 resident (R9) reviewed for transfer assistance. This resulted in actual harm for R25 when she slipped and fell on the freshly mopped, wet floor, struck her head on the concrete floor, and sustained a head laceration that required emergency medical evaluation and staples. Findings include: R25 R25's annual Minimum Data Set (MDS) dated 4/21/26, identified R25 had intact cognition, was independent with activities of daily living (ADLs), transfers and ambulation. R25 had not		20830	Corrected		09/02/2026	

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20830	Continued from page 4 experienced any falls since admission and/or the previous assessment. Diagnoses included repeated falls, dysthymic disorder, unspecified intracranial injury, osteoporosis, essential tremor, paroxysmal vertigo, gait and mobility abnormalities, weakness, urinary incontinence, seizures and disorientation. R25's care plan dated 5/5/26, identified an activity of daily living status. R25 believed herself capable of increased independence with bed mobility, transfers, walking in room and hall, dressing, eating, toilet use and personal hygiene. A goal was identified R25 would accept limitations of unsteady gait and function at her maximum capacity as evidenced by walking with staff when out of her room. Approaches included that R25's usual performance was substantial assist with bathing, supervision with shower transfer and setup with eating. R25 was independent with all other abilities. During interview on 7/27/26, at 6:49 p.m. R25 stated she had fallen in her room a few weeks prior, when she trying to go to the bathroom. The housekeeper had just mopped the floor, and she had slipped on the wet floor and fell. R25 stated she hit the back of her head on the floor during the fall and had to go to the emergency room where she received stitches to the back of her head. R25 stated a wet floor sign had not been placed, and she was not aware her floor was wet when she tried to ambulate to the bathroom. R25' The Patient/Resident Event Report Form dated 6/7/26, at 11:30 a.m. identified R25 had an unwitnessed fall in her room. The report identified R25 was coming out of the bathroom and the floor was wet and she slipped and hit the back of her head on the concrete floor. A one-to-two-centimeter laceration and egg like bruise was observed on the back of R25's head and she was sent to the emergency room to evaluate. Listed actions taken included assist of one in room and a physical therapy evaluation. The floor was confirmed to be wet. R25's CT Spine Cervical Without Contract Results dated 6/8/26, identified R25 had a CT of the brain and cervical spine was performed. There were no acute intracranial process and no acute fracture; however, the CT results did identify R25 did have a head laceration. No further hospital documentation was received from the facility. R25's progress note(s) identified the following: 6/7/26, R25 was found on her bedroom floor with a moderate amount of blood on the floor and the back of her head. R25 had stated she was up to use the restroom, but the floor had just been mopped and was slippery. R25 had slipped and fell and hit the posterior right side of her head. Area of head was cleansed and there was a one-to-two-centimeter laceration and a five-centimeter egg lump on the			20830			09/02/2026

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20830	Continued from page 5 back of her head. R25 denied pain and pupils were equal and reactive to light. Range of motion and hand grasps were within normal range. R25 was sent to the emergency room for further assessment. 6/7/26, R25 returned from the hospital at 1:30 p.m. and had received 8 staples to the back of her head. 6/13/26, identified the staples were present and the wound was dry, intact and had no signs of infection. During interview on 7/28/26, at 9:11 a.m. the director of nursing (DON) stated the event report was the only information on the fall and did not have evidence of an internal investigation into the events that lead to the missing wet floor sign or what corrective measures were taken by the facility following the fall. During interview on 7/29/26, at 7:03 a.m. housekeeper (HK)-A stated she usually waited to clean and mop resident rooms when the resident went out for meals or activities. If HK-A had to clean a room when the resident was there, she reminded the resident the floor was wet and to be careful and she always dry mopped the floor after mopping to ensure the floor was not to wet. HK-A stated she always placed a wet floor sign in the resident's doorway as well. The housekeeping staff had been told a resident had fallen on a wet floor and were given reminders to be sure to wring out their mops better, so the floor would not be too wet, as well as to use a dry mop over it. The housekeeping staff had also been told to inform the resident the floor was wet and to place a wet floor sign in their room. During observation on 7/29/26, at 11:36 a.m. HK-A was observed mopping a resident's room. The resident had exited the room to go to lunch and HK-A had wet mopped the floor and then used a dry mop to go over the entire floor. When she was finished, HK-A placed a wet floor sign in the doorway to the room. During interview on 7/30/26, at 9:35 a.m. HK-B stated she had mopped R25's floor on 6/7/26. HK-B did not know R25 was in the room when she cleaned, as she must have been in her bathroom at the time. Mopping was the last thing HK-B did before she finished the room. When HK-B heard R25 had fallen, the staff had told her there was no wet floor sign in the resident's room. HK-B was sure she had used one, but she may have taken it down to soon, before the floor was fully dry. A few of the facility nursing assistants had told her about it the next time she returned to work, however, no one else had talked to her about it or provided education. She did not think anyone else knew it was her that had cleaned the room that day. During an interview on 7/30/26, at 10:06 a.m., the DON stated that following R25's fall,			20830			09/02/2026

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20830	Continued from page 6 she met with staff who had been working that day. Staff confirmed R25's floor had been wet at the time of the fall. The housekeeper had recently mopped R25's floor and reported reminding R25 that the floor was wet; however, a wet-floor sign had not been placed. The DON stated she spoke with the housekeeping supervisor (HS)-C regarding the incident and understood that HS-C had spoken with the involved housekeeper and provided education. The DON was not able to provide evidence of staff education following the fall. During interview on 7/30/26, at 11:04 a.m. HS-C stated she had been notified a resident had fallen because of a freshly mopped floor about a week after the fall had occurred. HS-C had been told that a resident had gotten up to go to the bathroom, and the floor was wet from the housekeeper mopping and the resident had slipped and fell; however, was not aware of the injury. She had talked with the housekeepers and HK-B stated she had cleaned the room and then mopped the floor. HK-B said she had put a wet floor sign up and told the resident to be careful the floor was wet, but that she may have removed the wet floor sign to soon, before the floor was dry. HS-C reminded all her staff frequently about using the wet floor signs as they were there to protect the housekeeper as well as to alert others the floor was wet. The housekeepers did put the wet floor signs in the resident doorways and not in the resident's room as they did not want the residents tripping over the sign and also to alert staff coming in the room that the floor was wet. Most of the time the resident was not in the room during cleaning. That day the weather was very hot, and the facility air conditioner was not working, which may have contributed to delay drying of the mopped floor. HS-C had not done any formal audits of compliance using the wet floor signs or documented the actions and education that was provided to the housekeeper and the rest of the housekeeping staff. R9R9's annual MDS dated 4/17/26, identified R9 had severe cognitive impairment and required maximal assistance with dressing, grooming and toileting hygiene. R9 was dependent with transfers and bed mobility and was unable to ambulate. R9 did not have behaviors of rejection of care. Diagnoses included Alzheimer's disease, abnormal gait and mobility, history of transient ischemic attack (TIA) and stroke, heart disease and dementia. R9's care plan date dated 4/30/26, identified an ADL functional status with a goal R9 would not deteriorate as evidenced by maintaining her ability to be independent with bed mobility, transfers, walking and eating after setup. Approaches were listed and included R9's usual performance was substantial			20830			09/02/2026

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20830	Continued from page 7 assistance with toileting hygiene, bathing, dressing, partial assist with eating, and dependent with all other functional abilities. R9 was unable to ambulate and was switched to a two person stand and pivot transfer. During observation on 7/29/26, at 12:07 p.m. nursing assistant (NA)-C was assisting R9 from the bed to the wheelchair. NA-C assisted R9 to sit on the side of the bed and placed a gait belt around R9's waist. NA-C assisted R9 to stand and pivot transfer to her wheelchair. NA-C noted a need to check for incontinence care and proceeded to assist R9 back into bed for incontinence care. R9 had difficulty coming to a standing position, so NA-C called on his walkie talkie for assistance. NA-D entered the room and assisted NA-C to help R9 into a standing position and pivot transfer back into bed. NA-D exited the room and NA-C provided incontinence care to R9. NA-C assisted R9 back to a seated position on the edge of the bed and placed a gait belt around R9's waist. NA-C assisted R9 to stand and then pivot back into her wheelchair without another staff's assistance. NA-C then wheeled R9 to the dining room for lunch. During interview on 7/29/26, at 12:15 p.m. NA-C stated R9's ability to stand varied day to day and R9 was mainly an assist of one with transfers. Sometimes R9 was an assist of two for transfers and had to call for help when she had trouble with standing. R9 stood fine most of the time. When interviewed on 7/29/26, at 12:34 p.m. registered nurse (RN)-C stated R9 was an assist of two to transfer per the care plan. NA-C should have had two persons assist when assisting R9 to transfer in case something happened, like if she fell. During interview on 7/29/26, at 2:12 p.m. RN-A stated R9 was assist of two to transfer and was not able to ambulate. The nursing assistants were trained for what type of care each resident needed during their orientation. There was also a list on the nursing assistant clip board that listed all the changes with the residents, including any therapy changes. The nursing assistants also had access to the resident's care plans. During interview on 7/30/26, at 10:30 a.m. the DON stated R9's ability fluctuated from day to day and had recently had an increase in staff support for assistance. When changes were made to a resident's plan of care for increase assistance, it was passed on in shift reports and discussed in daily huddles. Staff should follow the resident plan			20830			09/02/2026

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20830	Continued from page 8 of care. The DON was sure it had been passed on in huddle and shift report but was not able to find the notes. The facility's Fall Prevention Program dated 3/20/26, identified goals that included to provide a comprehensive fall preventions program aimed at promoting patient safety with participation by the entire organization. Patients, residents, families and staff would be educated as appropriate on measures to prevent falls and implement interdisciplinary fall prevention interventions tailored to the resident. The plan identified universal fall precautions were to be implemented for all residents, as they were aimed at keeping the care environment safe. Universal fall precautions identified several approaches, which included to keep floor surfaces clean and dry and clean up all spills promptly. SUGGESTED METHOD OF CORRECTION: The DON or designee could review, and revise policies and procedures as needed regarding fall assessment/ investigation and ensuring process correction/interventions occur; and ensure fall interventions are followed.The DON or designee could develop a system to educate staff on the requirements. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20830			09/02/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.			20900	Corrected		09/02/2026

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NAME OF PROVIDER OR SUPPLIER KITTSOON HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH AVE , HALLOCK, Minnesota, 56728			
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20900	Continued from page 9 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to reposition a resident in accordance with the resident's established every two-hour turn and reposition schedule for 1 of 1 resident (R9) reviewed for pressure ulcer prevention and was at risk for developing pressure ulcers. Findings include; R9's annual Minimum Data Set (MDS) dated 4/17/26, identified R9 had severe cognitive impairment and required maximal assistance with dressing, grooming and toileting hygiene. R9 was dependent with transfers and bed mobility and was unable to ambulate. R9 did not have behaviors of rejection of care. Diagnoses included Alzheimer's disease, abnormal gait and mobility, history of transient ischemic attack (TIA) and stroke and dementia. R9's care plan dated 4/30/26, identified an activity of daily living (ADLs) functional status with a goal R9 would not deteriorate as evidenced by maintaining her ability to be independent with bed mobility, transfers, walking and eating after setup. Approaches were listed and included R9's usual performance was substantial assistance with toileting hygiene, bathing, dressing, partial assist with eating, and dependent with all other functional abilities. R9 was unable to ambulate and was switched to a two person stand and pivot transfer. The care plan also identified a risk for pressure ulcers with a goal R9's skin would remain intact. Approaches included staff to observe skin daily with care and nursing to complete a head-to-toe assessment weekly. R9 had a standard pressure reduction mattress. R9's Progress Note dated 7/26/26, identified R9 continued to be assist of two with transfer and assist of one with ADLs. R9 had a turn and reposition schedule when in bed and heels were to be off-loaded with a pillow. During continuous observation on 7/29/26, from 9:30 a.m. to 12:06 p.m. R9 was observed lying on her back with her arms extended down on either side. R9 was fully dressed and covered with a pink quilt. R9's bed was positioned in its lowest position, the lights to the room were off and the room was quiet. The door to her room was wide open. R9 was observed sleeping during the observation period and did not move on their own. No nursing staff entered the room during the observation period to offer			20900			09/02/2026

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20900	Continued from page 10 repositioning. On 7/29/26, at 12:07 p.m. nursing assistant (NA)-C entered R9's room, put on gloves, and explained to R9 he was there to get her up for lunch. NA-C sat R9 on edge of bed and placed a gait belt around her waist. NA-C pivot transferred R9 to her wheelchair. NA-C stated sometimes R9 was able to turn herself, unless she was tired, and then she needed help. NA-C stated he had not been in R9's room since he assisted her to lie down after breakfast. NA-C stated R9 did not currently have any open skin areas and could not identify if R9 should have been repositioned after two hours lying in bed, as he thought she was able to do so herself. During interview on 7/29/26, at 2:12 p.m. registered nurse (RN)-A stated the nursing assistants had a list of residents that required turning and repositioning every two hours on their clipboard. RN-A stated R9 was on the turn and reposition schedule, which included all residents that could not reposition themselves and all the residents on the list were to be repositioned every two hours. When interviewed on 7/30/26, at 10:30 a.m. the director of nursing (DON) stated R9's functional ability had been fluctuating back and forth. It was communicated during shift report and huddle when her care needs had increased. She was on a turn and reposition scheduled and the DON felt staff had not performed due to being nervous over being watched during survey. The facility's undated policy Activities of Daily living identified staff would provide assistance to residents as necessary. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to ensuring that resident's who required assistance to turn and reposition were provided timely assistance. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff repositioned residents who required assistance in a timely manner. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20900			09/02/2026

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20915	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 A Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide timely toileting assistance for 1 of 1 resident (R13) reviewed who had complaints of not receiving timely toileting assistance. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/22/26, identified R13 was cognitively intact and needed substantial/maximal assistance for transfers and toileting. R13 was continent of bowel and bladder. R13's diagnoses included stroke and irritable bowel syndrome (a condition which affects the large intestine) with diarrhea. R13's care plan dated 7/9/26 identified R13 needed assistance with toileting related to impaired mobility following a stroke. The care plan identified staff would respond promptly to requests for toileting assistance, provide one-person pivot transfers as indicated, and assist with toileting hygiene. R13's call light log from 7/10/26-7/23/26, identified four times R13 had waited from 24-35 minutes prior to their call light being answered. During an interview on 7/27/26 at 6:39 p.m., R13 stated I sometimes had to wait 30 minutes for			20915	Corrected		09/02/2026

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20915	Continued from page 12 assistance to the bathroom. Due to having to wait I soiled myself numerous times and became embarrassed. During an interview on 7/30/26 at 10:53 a.m., nursing assistant (NA)-B stated R13 had soiled their brief after having to wait more than 30 minutes. When we get busy, residents may have to wait longer than 30 minutes to getting assistance. During an interview on 7/30/26 at 11:50 a.m., registered nurse (RN)-A stated at times they do not have enough staff to help all the residents quickly. Nursing will assist the NAs in answering call lights at this time. I was not aware if a resident waited longer than 30 minutes, but they should not have waited that long. During an interview on 7/30/26 at 12:00 p.m., the director of nursing (DON) stated the facility policy is to have all call lights answered within 10 minutes and that is the expectation for staff. It would be unacceptable for residents to have to wait longer than 20 minutes before receiving help. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to ensuring that each resident received assistance with activities of daily living as directed in the resident plan of care. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff assisted residents as needed and promoted independence when able. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20915			09/02/2026
20920	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 B Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.			20920	Corrected		09/02/2026

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20920	Continued from page 13 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence care for 1 of 1 resident (R9) reviewed for activities of daily living and who were dependent on staff for their care. Findings include: R9's annual Minimum Data Set (MDS) dated 4/17/26, identified R9 had severe cognitive impairment and required maximal assistance with dressing, grooming and toileting hygiene. R9 was dependent with transfers and bed mobility and was unable to ambulate. R9 did not have behaviors of rejection of care. Diagnoses included Alzheimer's disease, abnormal gait and mobility, history of transient ischemic attack (TIA) and stroke, heart disease and dementia. R9's care plan date with revision date 4/30/26, identified an activity of daily living (ADLs) functional status with a goal R9 would not deteriorate as evidenced by maintaining her ability to be independent with bed mobility, transfers, walking and eating after setup. Approaches were listed and included R9's usual performance was substantial assistance with toileting hygiene, bathing, and dressing. During observation on 7/29/26, at 12:07 p.m. nursing assistant (NA)-C entered R9's room and notified R9 he would assist her up to go to lunch. NA-C put on disposable gloves and assisted resident to sit on the edge of the bed. NA-C placed a gait belt around R9's waist and assisted her into her wheelchair using a stand and pivot to transfer. When R9 stood up, her jeans were visibly wet along each outer buttock and hip area. After assisting R9 into her wheelchair, NA-C removed the gait belt and his gloves and wheeled her out to the hall. When asked if R9 used the toilet prior to meals, NA-C stated R9 did not and was check and change only, as R9 was incontinent. NA-C assisted R9 back into bed. NA-C confirmed R9's jeans were wet and put on gloves and removed her pants. R9's brief was saturated and R9 had been incontinent of bowel. NA-C removed the soiled brief and washed R9's peri area with disposable wipes. NA-C changed his gloves and put on a clean brief and clean pants. NA-C transferred R9 back into her wheelchair and assisted her to the dining room for her lunch meal. During interview on 7/29/26, at 12:10 p.m. NA-C stated he had not been in to check or change R9 since she was assisted to lie down after breakfast. NA-C stated he had not turned or checked for incontinence before transferring R9 to her wheelchair to go to lunch. NA-C thanked surveyor for noting R9 jeans were wet as he would not have liked for her to			20920			09/02/2026

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20920	Continued from page 14 be in a soiled brief and he had forgotten to check her. During interview on 7/29/26, at 2:12 p.m. registered nurse (RN)-A stated R9 was incontinent of both bowel and bladder and should be checked every two hours and changed when needed. During interview on 7/30/26, at 10:30 a.m. the director of nursing (DON) stated R9 had been fluctuating back and forth with her care needs but with the hot weather it was especially important to push fluids and keep residents clean and dry. The DON knew residents were not left in soiled briefs and felt the staff was too nervous about being watched and went to quickly, anxious about getting the resident to the dining room and forgot steps. The facility's undated policy Activities of Daily Living (ADL) identified several purposes which included to provide assistance to residents as necessary. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to ensuring that each resident received the assistance they required as outlined in the resident's plan of care. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff assisted all dependent residents as they required. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20920			
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			21390	Corrected		09/02/2026

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21390	Continued from page 15 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 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 its antibiotic stewardship protocols for the assessment and monitoring of antibiotic use for 1 of 2 residents (R9) reviewed for antibiotic use. R9 received repeated courses of antibiotics for suspected urinary tract infections (UTIs); however, the facility failed to use its established UTI assessment process and failed to complete, and document required 72-hour antibiotic reassessments to evaluate the continued need, duration, and selection of antibiotic therapy. In addition, the facility failed to implement Enhanced Barrier Precautions (EBP), including the use of gowns and gloves during high-contact resident care activities, f1 of 1 resident (R18) reviewed for catheters and 1 of 1 resident (R29) reviewed who was receiving wound care. In addition, the facility failed to conduct ongoing infection surveillance to identify and track residents with signs and symptoms of potential infection for 1 of 1 resident (R1) reviewed for infection surveillance. Findings include: R9's annual Minimum Data Set (MDS) dated 4/17/26, identified R9 had severe cognitive impairment and required maximal assistance with dressing, grooming and toileting hygiene. R9 was frequently incontinent of bowel and bladder. R9 did not have behaviors of rejection of care. Diagnoses included Alzheimer's disease, abnormal gait and mobility, history of transient ischemic attack (TIA) and stroke, heart disease and dementia. R9's care plan dated 4/30/26, identified an activity			21390			09/02/2026

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21390	Continued from page 16 of daily living (ADLs) functional status with a goal R9 would not deteriorate as evidenced by maintaining her ability to be independent with bed mobility, transfers, walking and eating after setup. Approaches were listed and included R9's usual performance was substantial assistance with toileting hygiene, bathing, dressing, partial assist with eating, and dependent with all other functional abilities. R9 was frequently incontinent of bowel and bladder and required assistance with peri care. R9's Physician Order Report dated 6/29/26 to 7/29/26, identified several medications, including cephalexin 500 milligrams (MG) three times per day 7/10/26 to 7/16/26. Cephalexin was again ordered 500 mg two times per day 7/21/26 to 7/29/26. R9's Progress Notes identified the following: 7/9/26, R9 was lethargic and had a temp of 99. and elevated pulse of 113. Rhonchi (rattling) was noted throughout lungs. R9 had been seen in the emergency department (ED) and returned with a diagnosis which included acute cystitis. A new order was received for cephalexin 500 mg three times per day for seven days. 7/17/26, R19 had completed antibiotic treatment with no complaints of pain or discomfort. She was noted to have bilateral edema (swelling) in her lower extremities, and her primary care provider (PCP) was updated. 7/20/26, R19 returned from a clinic appointment and Rocephin 1 gram had been administered intramuscularly (IM) at the appointment. New orders were received for Nitrofurantoin 100 mg two times per day for cystitis/urinary tract infection. 7/21/26, R19's antibiotic was changed from Nitrofurantoin to cephalexin due to resident required medications to be crushed and unable to crush Nitrofurantoin. 7/28/26, R19 completed her last dose of cephalexin and denied pain or burning. R19's lab results were reviewed 6/8/26 through and identified the following: 6/8/26, a urinalysis was obtained and cephalexin 500 mg two times per day for five days was ordered. A urine culture was in process, however R19's medical record lacked the results of the culture. 7/13/26, identified R19 had Escherichia coli (e. coli,			21390			09/02/2026

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21390	Continued from page 17 a bacteria) was present in her urine noted from the urinalysis obtained 7/9/26, and was sensitive to the cephalixin antibiotic treatment that was ordered. R9's medical record was reviewed from 6/1/26 through 7/28/26, lacked any further urinalysis or culture results, despite having received three courses of antibiotic treatment during the time frame. During interview on 7/30/26, at 10:30 a.m. the director of nursing (DON) stated the facility's consultant pharmacist was in charge of the facility's antibiotic stewardship program, however, was not available during survey and could not be reached via phone. The DON stated she had recently provided education to the facility staff on ways to prevent resident urinary tract infections, such as increasing fluids and frequent peri care and assistance with toileting. R19 was declining in health and did not drink a lot of fluids. The facility had recently increased R19's fluids with meals and throughout the day and educated the staff on the new interventions. The facility used Situation, Background, Assessment and Recommendation (SBAR) forms specific for urinary tract infections (UTI) to communicate with resident's primary care providers. The UTI SBAR required the nurse to note the resident vital signs, and if symptoms of pain or burning with urination, temperature, or two or more symptoms such as urgency, blood in urine, incontinence of frequency was noted. The provider could respond with suggested orders as indicated on the bottom of the form. The DON was not able to provide the SBAR communication forms that were communicated the R19's PCP. The DON stated the staff do try to push fluids first for a suspected UTI, but they also wanted to notify the physician quickly because they had some residents that would show delayed symptoms and were very sick by the time they demonstrated symptoms. When interviewed on 7/30/26, at 11:52 a.m. registered nurse (RN)-B stated she had accompanied R9 to her provider appointment on 7/20/26, when she was given an injection of Rocephin and an antibiotic had been ordered. The provider did not feel more labs were needed and did not want to obtain a urinalysis or culture. The physician felt R9 still had cystitis and so just treated her with the Rocephin and oral Nitrofurantoin which then was changed to cephalixin. The consultant pharmacist did the facility antibiotic stewardship. Typically, when staff suspected a resident had a UTI, they pushed fluids, monitored, noted the urine, but it was an informal process. The SBAR was just to notify			21390			09/02/2026

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21390	Continued from page 18 the provider of the resident's symptoms at the time of notification and was not a formal three-day type of process to ensure the staff have monitored and tracked symptoms before physician contact. The facility policy Antibiotic Stewardship with revision date 5/25, identified patients who needed antimicrobial therapy would get optimal drug selection, dose, duration and route to maximize patient outcomes, minimize side effects and decrease the emergence of resistance. Providers would utilize the Loeb criteria when considering the initiation of antibiotics. Consistent with the criteria, the UTI SBAR form would be used for all residents suspected of having a UTI. At 72 hours after antibiotic initiation the resident would be reassessed for consideration of antibiotic need, duration, selection and escalation potential. Laboratory testing results, response to therapy, resident condition and facility needs would be considered. Completion of antibiotic time-out must be recorded in the resident record. The facility would monitor antibiotic use, stewardship actions, and outcomes related to antibiotics in order to guide practice change and impact. R18 R18's quarterly Minimum Data Set (MDS) dated 6/8/26, identified moderate cognitive impairment and was incontinent of bowel and bladder. R18's diagnoses include chronic kidney disease stage 3 and retention of urine-chronic (long term). R18's Health Service Referral Form discharging hospital dated 6/17/26, identified R18 was admitted back to the facility following hospitalization with a discharge plan of maintaining Foley (indwelling) catheter related to urine retention. R18's provider orders dated 6/26/26, identified R18 had a Foley catheter. During observation on 7/29/26 at 7:09 a.m., registered nurse (RN)-A had just completed a dressing change and assisted R18 to get comfortable in bed by placing pillows under his head and behind his back and then covered him with a blanket while waiting for the nursing assistant (NA)s to come in and assist R18 with getting dressed. RN-A was not wearing a gown while assisting R18 with bed mobility. During observation on 7/29/26 at 7:11 a.m., NA-A and NA-D entered the room and assisted R18 in getting dressed. Both NAs sanitized their hands and			21390			09/02/2026

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NAME OF PROVIDER OR SUPPLIER KITTSO N HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH AVE , HALLOCK, Minnesota, 56728			
(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
21390	Continued from page 19 put on gloves prior to assisting R18. The NAs assisted R18 to roll from side to side, placed an incontinent brief, shirt and socks on. NA-A unwrapped the Foley catheter tubing from around R18 leg before threading it through R18's pants leg. NA-A then washed hands with soap and water in the bathroom. In the bathroom there were gowns and gloves on the door with a sign identifying enhanced respiratory precautions. NA-A came back out of bathroom and placed gloves on and NA-A and NA-D placed transfer sling under resident and used a total lift to transfer him to the wheelchair. During observation on 7/29/26 at 7:29 a.m., the hospital lab tech (HLT) entered R18's room to draw blood from R18. The HLT sanitized his hands and prepared his supplies, then sanitized his hands again and put on gloves and drew 2 vials of blood from R18. HLT was only wearing gloves when in direct contact with resident. During an interview on 7/29/26 at 7:29 a.m., the HLT stated he did not know R18 was on EBP and pointed out there was no signage to indicate EBP and did not get an update from staff. If I had known, I would have worn a gown and gloves. During an interview on 7/29/26 at 8:29 a.m., NA-A stated their understanding was they would only need to wear a gown and gloves while providing catheter care and did not do it with other direct resident contact. There were PPE supplies in the R18's bathroom for use with catheter cares. During an interview on 7/29/26 at 9:53 a.m., NA-D stated they had only been working at the facility for a couple of weeks and got three days of orientation. During the time it was explained they would need to wear a gown and gloves when doing catheter care for R18, or if the nurse was doing a dressing change. She stated she had not realized R18 was on EBP and stated it was not on the Kardex (a quick reference for care plan). During an interview on 7/29/26 at 2:10 p.m., the director of nursing (DON) stated staff were expected to use EBP with residents when they provided any catheter cares or wound dressings. The DON also touched base with infection preventionist when any precautions are instituted. Staff were also expected to follow the policy if there are any questions. R29 R29's quarterly MDS dated 6/20/26, identified R29 had moderate cognitive impairment and diagnoses			21390			09/02/2026

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21390	Continued from page 20 that included chronic heart failure, pressure ulcer, peripheral vascular disease and chronic kidney disease. R29 was at risk for developing pressure ulcer/injury and had no unhealed pressure ulcer/injuries. R29 used a pressure reducing device for her bed and chair and had an application of a nonsurgical dressing. R29’s care plan revised 7/12/26, failed to identify R29’s need for enhanced barrier precautions due to having a pressure ulcer. During an observation on 7/29/26 at 7:33 a.m., NA-A and NA-B entered R29’s room but did not put on a disposable gown. Both walked past the personal protective equipment cart hanging on the backside of R29’s bathroom door. There were disposable gowns and gloves available with signage indicating R29 required contact precautions. At 7:34 a.m., R29’s foam border dressing was loose and no longer covered R29’s pressure ulcer wound. NA-A and NA-B assisted R29 to use the bedpan, then transferred R29 from her bed to the wheelchair using a fully body mechanical lift. At 7:43 a.m., NA-A and NA-B removed their soiled gloves and assisted R29 to the shower room. At 8:16 a.m., NA-A and NA-B returned to R29’s room with R29 and transferred R29 back into bed using a full body mechanical lift to finish dressing. R29’s foam border dressing had been removed and R29’s wound was exposed. Neither NA-A nor NA-B were wearing disposable gowns. At 8:47 a.m., registered nurse (RN)-A entered to assist R29 with her stockinette and to assess R29’s wound. RN-A did not put on a disposable gown. During an interview on 7/29/26 at 8:59 a.m., NA-A and NA-B Earnistine stated R29 has a wound, so staff always had to wear gloves but pointed to the sign and stated if there's any drainage then they had to wear a gown. Only then. During an interview on 7/29/26 at 9:05 a.m., RN-A stated staff only needed to wear a gown and gloves when doing the dressing for the wound and it was not needed at any other time. During an interview on 7/29/26 at 12:25 p.m., DON and RN-B stated staff were expected to wear a gown and gloves during wound care and when R29 needed to use the bed pan, potentially. The DON stated she was unaware that a contact precautions sign was			21390			09/02/2026

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21390	Continued from page 21 hanging on R29’s PPE cart and it should have been enhanced barrier precautions because R29 had a pressure ulcer. Staff were expected to follow Centers for Disease Control and Prevention (CDC) guidelines and wear a disposable gown and gloves whenever providing care for R29 to prevent the potential transmission of infection to R29. A facility policy related to Enhanced Barrier Precautions was requested but not received. The Centers for Disease Control and Prevention guidance dated 6/28/24, identified Enhanced Barrier Precautions were an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). SURVEILLANCE R1 R1’s quarterly MDS dated 5/28/26, identified R1 had a moderate cognitive impairment and diagnoses that included Post Traumatic Stress Disorder (PTSD) and anxiety. R1 was independent with eating, toileting, hygiene, transfers and walking. R1’s care plan revised 5/30/26, identified R1 experienced differences in ability to perform activities of daily living (ADLs) related to dementia. Staff were directed R1 was independent with eating, toileting, hygiene, dressing/footwear, bed mobilities, transfers and walking. Supervision of 1 with personal hygiene and substantial assist of 1 with bathing. R1’s nursing note dated 7/25/26 at 5:34 p.m., identified R1 refused to eat breakfast, said she was not hungry. Did take 240 milliliter (ml) chocolate ensure (nutritional shake) with her medications. R1 said she had been sick with diarrhea. The facility Nursing Home Infection Control Log dated May 2026, identified the resident name, date, onset date, site, infection related diagnosis, culture yes/no, organism, antibiotic, isolation yes/no, nosocomial (did the infection originate in the facility) yes/no and follow up. The log identified 1 cellulitis (a common, potentially dangerous skin infection), 3 urinary tract infections (UTI), 1 leg wound and 1 paronychia (an infection or inflammation of the skin			21390			09/02/2026

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21390	Continued from page 22 fold around a fingernail or toenail). Only 1 culture was identified, and 1 UTI provided no further information. Additionally, the log failed to identify any infectious symptoms not treated with an antibiotic. The facility Nursing Home Infection Control Log dated June 2026, identified the resident name, date, onset date, site, infection related diagnosis, culture yes/no, organism, antibiotic, isolation yes/no, nosocomial (did the infection originate in the facility) yes/no and follow up. The log identified 2 cellulitis, 1 vaginal infection, 2 pneumonia, 1 great toenail removal, and 3 UTI. No cultures were identified and 1 UTI was identified as “none”. Additionally, the log failed to identify any infectious symptoms not treated with an antibiotic. The facility Nursing Home Infection Control Log dated July 2026, identified the resident name, date, onset date, site, infection related diagnosis, culture yes/no, organism, antibiotic, isolation yes/no, nosocomial (did the infection originate in the facility) yes/no and follow up. The log identified 4 UTI, 1 g-tube infection, 1 eye infection, a leg infection, 1 lung infection, 2 cellulitis and 1 resident treated with an antibiotic with no other information provided. Additionally, the log failed to identify any infectious symptoms not treated with an antibiotic and failed to identify R1’s diarrheal symptoms on 7/25/26. During an interview on 7/28/26 at 1:58 p.m., the facility infection preventionist (IP)-A stated she was responsible for the facility’s education coordination and gathering surveillance data to report for IP during the QAPI meeting. Once per month, IP-A received the Nursing Home Infection Control Log from the director of nursing (DON), usually at the beginning of the following month. If something were to come up during the month, it would be discussed during the interdisciplinary team (IDT) meeting. IP-A also collected data for the Risk meeting as well, but it was basic information such as numbers of infections and the number of line days for the facility. During an interview on 7/30/26 at 2:51 p.m., the DON stated nursing was responsible for entering a nursing note and the DON would review the notes to add the infections to the Nursing Home Infection Control Log. Then, at the end of the month, she provided the log to IP-A to review the information. However, viral infections were not added to the log. The DON stated she used to try to keep track of everything, but she had so much on her plate she just wasn’t able to get it all done. However, all			21390			09/02/2026

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21390	Continued from page 23 signs/symptoms of infection should have been tracked to prevent the potential spread of infection. The facility policy Infection Surveillance revised 5/2025, identified infection prevention began with routine and ongoing surveillance to identify possible communicable diseases or infections before they could spread to other persons in the facility or have the potential to cause an outbreak. The policy directed the following: The unit charge nurses will identify residents with symptoms or identified infections and complete the Criteria for Infection Report Forms for the respective type of infection and report to the IP: UTI, respiratory tract infection; gastrointestinal tract infection; skin, soft tissue and mucosal infections. The IP will ensure data collection to complete a comprehensive monthly infection control log for the surveillance activities on: Site Pathogen Signs and symptoms Resident location Summary and analysis of number of residents and/or staff with infections Observations of staff adherence to policies and procedures. identification of outcomes that were unusual or unexpected that could potentially lead to patterns, trends or outbreaks. The IP or designee would be alerted to identify any necessary interventions in or to identify trends or clusters for action. The IP would keep an updated map of infections to identify any clusters or trends. Data obtained from process surveillance audits would be collected to analyze the compliance of staff with facility policies and procedures. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and			21390			09/02/2026

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21390	Continued from page 24 procedures related to ensuring that residents with suspected symptoms of illness and/or infection were evaluated using the facility's SBAR forms and residents were reassessed after initiation of antibiotic treatment; ensure EBP are utilized and all residents with signs and symptoms of infection as tracked and analyzed to prevent facility outbreaks. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete assessments and laboratory results were reviewed to ensure appropriate antibiotic treatment, ensure staff use EBP and track all residents with signs and symptoms of infection. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21390			09/02/2026