



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2026

Administrator

GOOD SAMARITAN SOCIETY - ST JAMES

1000 SOUTH SECOND STREET

ST JAMES, MN 56081

RE: CCN:245593

Cycle Start Date: July 28, 2026

Dear Administrator:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Heath Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 28, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 28, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245593		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/27/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST JAMES				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SOUTH SECOND STREET , ST JAMES, Minnesota, 56081			
(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 Code survey was conducted on 07/27/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society - St. James 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			08/21/2026

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

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society - St. James is a one-story with partial basement facility was determined to be of Type V(000) construction and is fully sprinklered throughout. The original building was constructed in 1963 with building additions in 1965, 1993, 1996, 2002. The facility has a capacity of 42 beds and had a census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			08/21/2026
K0222 SS = F Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use			K0222	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial		07/28/2026

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K0222 SS = F Bldg. 01	Continued from page 2 of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS			K0222	Continued from page 2 compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. All residents had the potential to be affected by the deficient practice. The facility maintenance director contacted Wilcon Construction on the day of the survey when the deficient practice was identified. Wilcon Construction ground down the concrete at the front of the door that was causing the door to not open appropriately on the next day, 7/28/2026. The door is now in compliance with acceptable standards. All residents could negatively be affected by the deficient practice. The egress door could not be easily opened in the case of an emergency which required evacuation. A whole house audit was conducted on all egress doors to ensure all exit doors are operational and meet requirements. The maintenance department is responsible for ensuring ongoing compliance. The maintenance director or designee will complete a daily inspection audit of all exit doors and will documents their findings for four weeks. Monthly audits will be conducted for two months to ensure ongoing compliance. The maintenance director is responsible for continued compliance by keeping records of the inspections. The audits will be reviewed by the QAPI committee.		07/28/2026

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K0222 SS = F Bldg. 01	Continued from page 3 Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.1.10.1 and 7.2.1.4.5.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/27/2026 at 12:35 PM, it was revealed by observation that the egress door located near the Laundry room was difficult to open.An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0222			07/28/2026
K0351 SS = F Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by:			K0351	All of the residents in the facilities have the potential to be affected by the deficient practice. The maintenance department installed a padlock on the breaker arm in the main boiler room on the day of survey, 7/27/2026. This is now in compliance with acceptable standards. All residents could potentially be impacted by this deficient practice. The breaker arm is part of the sprinkler control system which is critical in situations which fire suppression is required or in situations where the system should be activated but fails. The maintenance department installed a breaker lock on the breaker arm to prevent the arm being moved into the "off" position. The maintenance director or designee will complete a weekly audit to ensure the breaker is locked and will document their findings for four weeks. The maintenance director or designee is responsible for continued compliance and inspections. The audits will be reviewed by the QAPI committee.		07/28/2026

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K0351 SS = F Bldg. 01	Continued from page 4 Based on observation and staff interview, the facility failed to install fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.1.1(1), and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 7.2.6.2.1. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 07/27/2026 at 12:46 PM, it was revealed by observation that the air compressor for the dry pipe sprinkler systems in the building was wired to a switch that was not locked in the "ON" position preventing the power from being turned off to the air compressor. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0351			07/28/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101			K0920	All of the residents in the facilities have the potential to be affected by the deficient practice. The maintenance department has removed the power strip and relocated the refrigerator to a new location where the cord is plugged directly into the wall outlet on 7/27/2026. This deficient practice has the potential to impact all residents if a power surge/failure were to impact the building. A whole house audit was completed, and no other instances were noted. The maintenance department is responsible for ensuring compliance. The maintenance director or designee will complete a weekly inspection for four weeks to ensure power strips are no longer being used on any office wing refrigerators. After the initial weekly inspections for four weeks the audits will be conducted monthly. The maintenance director or designee will complete a weekly inspection for four weeks to ensure power strips are no longer being used on any office wing refrigerators. After the initial weekly inspections for four weeks the audits will be conducted monthly. The audits will be reviewed by the QAPI committee.		07/28/2026

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K0920 SS = E Bldg. 01	Continued from page 5 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 07/27/2026 at 11:58 AM, it was revealed by observation that a refrigerator was plugged into a power strip in the Business Office. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0920			07/28/2026
K0741 SS = B Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on document review, observation, and staff interview, the facility failed to enforce smoking			K0741	Residents of the facilities have the potential to be affected by the deficient practice. The maintenance department has installed the required signage on 7/27/2026. The facility is now in compliance. This deficient practice has the potential to impact some or all residents inside the facility. Impact may occur if smoking occurs inside the building, resident room, or group areas within the building. A whole house audit was completed for all major entrances/exits at the facility. Appropriate signage was placed at the entrances. The maintenance department is responsible for ensuring compliance. The maintenance director or designee will complete a weekly inspection for four weeks to ensure signage is placed in appropriate areas. After the initial weekly inspections for four weeks the audits will be conducted monthly. The maintenance director will ensure continued compliance by keeping and maintaining inspection records. The audits will be reviewed by the QAPI committee.		07/28/2026

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K0741 SS = B Bldg. 01	Continued from page 6 policies per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.4. This deficient finding could have a patterned impact on the occupants within the facility. Findings include: On 07/27/2026 at 12:52 AM, it was revealed by observation that there was not NO SMOKING signs prominently placed at all major entrances. An interview with the Maintenance Director verified this deficient finding at the time of discovery			K0741			07/28/2026
K0363 SS = A Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			K0363			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245593		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/27/2026	
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K0363 SS = A Bldg. 01	Continued from page 7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 18.3.6.3.10. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 07/27/2026 at 11:56 AM, it was revealed by observation the door to the Business Office was propped open with a rubber wedge. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0363			08/28/2026

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E0000	Initial Comments On 7/27/26-7/28/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			08/21/2026	
F0000	INITIAL COMMENTS On 7/27/26-7/28/26, a standard recertification survey (S#5593039) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55933473C (2994042), H55933475C (2792406), H55933474C (1159657). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000				08/21/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care			F0684				

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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F0684 SS = D	Continued from page 1 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide supervision and supply adequate resources to protect skin from sun exposure for 1 of 1 resident reviewed for hospitalization. Findings include: R45's quarterly Minimum Data Set (MDS) assessment dated 5/20/26, indicated he needed partial/moderate assistance with upper body dressing and personal hygiene and substantial/maximal assistance with lower body dressing. Diagnoses included heart failure, renal (kidney) failure, arthritis, and dementia. Brief Interview for Mental Status (BIMS) showed moderate cognitive impairment. R45's care plan printed 7/28/26, indicated impaired cognitive function evidenced by occasional memory lapses and repeating self. R45 needed assistance with self-care and mobility. R45 was at risk for nutrition and hydration problems. R45 was at risk for dehydration. Incident reports were reviewed for the past six months and indicated no reports regarding sunburn for R45. Progress notes were reviewed for the past month. No notes indicated R45 had been sun burned. During observation on 7/27/26, it was noted on the activity calendar that a "Fun Day" event was scheduled on 7/10/26. On 7/27/26 at 11:20 a.m., R45 reported he had been hospitalized about a month and a half ago following an outside carnival event at facility. R45 stated he spent four days in the hospital after he spent too much time in the heat. R45 stated, "I don't know if it was 100 (degrees) but it was a warm one." R45 reported the activity started at 9 a.m. and he had been outside until the middle of the afternoon. R45 reported he had consumed his lunch outside and			F0684	Continued from page 1 and/or executed solely because it is required by provisions of federal and state law. For purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and Plan of Correction constitutes the center's allegation of compliance in accordance with Section 7305 of the State Operations Manual. 1.R45 was assessed and received appropriate medical evaluation and treatment at the hospital from 7/11/26-7/13/26. The resident's care plan was reviewed and updated to include individualized interventions related to outdoor activities and prevention of sun-related injury, including appropriate supervision/monitoring, sunscreen application, access to shade, protective clothing, hydration, and limitations on duration of sun exposure based on the resident's assessed needs and preferences. 2. The interdisciplinary team (IDT) have reviewed residents who routinely spend time outdoors to identify those who may be at risk for sun-related injury. Care plans will be reviewed and updated as indicated to include individualized interventions such as sunscreen application, protective clothing, access to shade, scheduled monitoring, hydration, supervision, and/or limitations on duration of sun exposure based on each resident's assessed needs, abilities, and personal choices. 3. Nursing and Activities staff received education regarding the facility's policy and procedures related to Activity Outings and Outdoor Engagement, recognition and prevention of sun-related injury, and the importance of developing and implementing individualized care plan interventions for residents who spend time outdoors. This education was delivered prior to 8/21/26 by the DNS or designee. Education will include staff responsibility for following established care plan interventions and reporting changes in resident condition or concerns related to heat or sun exposure to the licensed nurse. Furthermore, "Beat the Heat" posters have been posted throughout the facility. 4. The Director of Nursing or designee will conduct audits of residents identified as routinely spending time outdoors to verify that:		08/21/2026

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F0684 SS = D	Continued from page 2 could not recall exactly what he had drunk while outside. R45 reported staff hadn't recommended he go inside and he went inside on his own after he ate dinner. R45 reported feeling unwell upon his return to his room. R45 stated he was dizzy and was sure it was from being out in the heat and sun. R45 stated he reported this to staff. On 7/27/26 at 4:45 p.m., nursing assistant (NA)-A was interviewed via phone. NA-A reported she had worked the day following the "Fun Day" activity. NA-A stated it had been hot and sunny that day. NA-A stated R45 had gotten sun burned after being outside for a couple of hours, adding his skin had always been "super sensitive." NA-A stated she had observed other residents with red arms but had not seen R45. NA-A stated staff had been told in the past they could not apply sunscreen to residents. NA-A stated she had been told in nurse report that some residents had been sunburned. NA-A reported another staff member brought in a bottle of aloe for the residents to soothe their skin. NA-A was unable to recall if there had been any education provided following this incident. On 7/27/26 at 5:05 p.m., trained medication aide (TMA)-A reported the "Fun Day" activity started at 11 a.m. but some residents had gone outside as early as 10:30 am. Residents had lunch outside and everyone came in around 12:30-1 p.m. TMA-A reported some residents looked pink like they'd been in the sun. TMA-A recalled it had been warm that day. TMA-A stated R45's skin had been the worst with redness observed on both arms. TMA-A was unaware of any interventions to prevent sunburn. TMA-A stated R45's arms remained pink when he returned from the hospital on 7/13/26. TMA-A did not recall having received any education following this incident. On 7/27/26 at 5:10 p.m., R21 stated she had attended the "Fun Day" activity. R21 verified activity started at 11 a.m. and lunch was served outside. R21 stated it had been sunny and probably 85 degrees or so. R21 stated she was outside for a couple of hours. R21 stated she did not get sun burned but reported having applied her own sunscreen. On 7/27/26 at 5:14 p.m., activities director (AD)-A reported residents had been outside for the "Fun Day" activity earlier than normal. AD-A reported the activity started between 10:30-11 a.m. Residents were served lunch outside and came back inside around 2:30 p.m. AD-A stated it was warm and sunny that day. (According to an internet search, weather conditions on 7/10/26 had been 82 degrees			F0684	Continued from page 2 Individualized sun-safety interventions are included in the resident's care plan when indicated. Staff are implementing the interventions identified in the resident's care plan. Residents are being monitored/supervised according to their assessed needs and care plan. Identified concerns or changes in condition are appropriately addressed and documented. Audits will be completed weekly x four weeks and monthly x three months. Audit findings will be reviewed by the QAPI Committee for further recommendations.		08/21/2026

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F0684 SS = D	Continued from page 3 Fahrenheit, sunny, with 60% humidity). AD-A stated some residents went outside by themselves and others had staff assistance. Not all residents stayed out for the duration of the activity and if they wanted to go inside early, they did. Following the activity some of the residents had red skin. AD-A verified R45 attended the activity. R45 had been wearing short sleeves. After lunch R45 said he was done and went inside. R45 did not indicate to AD-A he felt unwell. AD-A stated they provided beverages available for the residents outside. AD-A stated it is their practice to offer sunscreen to the residents but it hadn't been done the day of the activity. AD-A stated typically she would be responsible for applying the sunscreen and had Coppertone 50 SPF in the activities bag. AD-A was unaware if the residents skin had been assessed following the activity. AD-A stated no facility wide education had been completed following the incident but reported she had spoken with the other activity department staff to remind them to offer sunscreen. On 7/27/26 at 5:55 p.m., TMA-B was interviewed via phone. TMA-B reported she had worked the evening shift on 7/10/26. TMA-B stated her shift started at 3 p.m. and the activity was already finished. TMA-B stated there had been redness on some of the resident's skin, particularly arms and necks. TMA-B stated she visualized this on two or three residents. TMA-B reported one resident was much redder than the others and she identified this resident as R45. TMA-B stated she reported this to the nursing staff. TMA-B stated that when she worked the day shift she always made sure residents had a hat, sunglasses and sunscreen on if going outside. TMA-B was unaware what the facility had for sunscreen or if residents had their own. TMA-B stated historically they had a bottle of sunscreen in the medication cart or activities had it. On 7/28/26 at 9:11 a.m., family member (FM)-A was interviewed via phone. FM-A stated he had been aware of R45's recent hospitalization and spent time with him in the ER. FM-A stated R45 was a little "woozy" and nodding off. FM-A stated the hospital told him it was a combination of things. R45 was dehydrated and had been limiting his meal portions due to concerns about his weight. FM-A stated R45 had a little bit of sunburn on both arms from the activity which could have added to the equation. FM-A stated both arms were pink. FM-A stated facility staff reported taking R45 outside in the shade. FM-A reported R45 is now back to his baseline. On 7/28/26 at 9:22 a.m., LPN-A was interviewed via			F0684			08/21/2026

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F0684 SS = D	Continued from page 4 phone. LPN-A stated day shift nursing staff reported the residents had been outside and they were sunburned. LPN-A observed three residents had reddened skin to their faces and arms. LPN-A identified R45 as one of the three residents. LPN-A was unaware if the residents had been offered sunscreen. LPN-A stated they would have been expected to notify the provider regarding the resident's red skin but gave them "the benefit of the doubt to see if it would calm down." LPN-A had encouraged staff to provide additional fluids that evening. LPN-A stated another staff member went home on break and brought back something (aloe) to help with the sunburns and it had been used on the three residents identified. LPN-A denied having a provider order to do so. LPN-A stated no education had been provided to staff following this incident. LPN-A stated she would have expected residents to be offered sunscreen and the provider should have been notified. On 7/28/26 at 9:39 a.m., interim director of nursing (IDON) reported she had been present at the facility the day of the activity. IDON reported the activity started in the morning and took place until after lunch time. IDON stated nothing had been reported to her about the residents after the event. She had not been informed of residents having sunburns. IDON stated it should be their practice to apply sunscreen prior to outdoor activities. IDON had been unaware staff had brought in aloe after red skin had been observed. IDON confirmed the provider should have been contacted since a provider order would be necessary to apply aloe. IDON stated residents should have been assessed to see if they were burned in order to get appropriate treatment for them. IDON confirmed education should have been provided to staff. On 7/28/26 at 9:54 a.m., former administrator was interviewed via phone. Administrator stated she had been present on the day of the outside activity. Stated she had brought R45 inside at approximately 12:30 p.m. after he was finished eating lunch. Administrator stated lunch was served in the sun. Administrator stated R45 asked to go inside because he was hot. R45 had not reported any other symptoms at that time. Administrator stated she had not noticed any concerning discoloration to R45's skin. Administrator stated she had not received any reports of residents who had reddened skin. Administrator had not been aware a staff member had brought in aloe. Administrator stated that sunscreen had not been provided to residents. Administrator did not know the facility's protocol for sunscreen use but it "absolutely could have been			F0684			08/21/2026

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F0684 SS = D	Continued from page 5 applied." Administrator further stated, "it wasn't on our brain and no one was complaining." Administrator reported it had been hot, "staff was hot, we were all hot." Administrator reported they had a cooler with beverages outside, and every resident had received a drink. On 7/28/26 at 10:44 a.m., registered nurse (RN)-B, also known as the regional clinical manager, had been present for the “Fun Day” activity. RN-B reported staff had done their best to keep the residents in the shade. Facility had ordered a tent for the residents to eat under but it "fell through" so they had eaten in the sun. RN-B stated "this is the first time I'm hearing about sunburn". RN-B stated she would have expected sunscreen to be offered to residents before an outdoor activity. RN-B stated there was sunscreen in the activity department. RN-B stated she would have expected the provider be notified if residents were sunburned. Facility Activity Outings and Outdoor Engagement - ACT policy dated 11/17/25 includes the use of proper safety techniques and provide supervision as needed for residents requiring additional assistance during outdoor engagement. Employees should bring an outing bag that includes potential items of need (i.e. transfer belts, disposable gloves, personal protective equipment (PPE) supplies, adult pads, garment protectors, toiletries, etc.) Weather conditions should be considered when participating and pursuing outdoor and community outings. (i.e., active weather alerts, warnings, watches, advisories, road conditions, temperatures, heat index, etc.). Facility Notification of Change policy dated 12/12/25 indicated a facility must immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative(s) when there is: An accident involving the resident which results in injury and has the potential for requiring physician intervention. A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment. Standing orders dated 4/2025 did not include the use of sunscreen.			F0684			08/21/2026