



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 27, 2026

Administrator
MOOSE LAKE VILLAGE
710 SOUTH KENWOOD AVENUE
MOOSE LAKE, MN 55767

RE: CCN:245491

Cycle Start Date: July 9, 2026

Dear Administrator:

On July 9, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Office: 218-302-6186 Mobile: 651-279-5375

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 9, 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).

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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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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MOOSE LAKE, MN 55767

Re: State Nursing Home Licensing Orders

Event ID: 235F47-H1

Dear Administrator:

The above facility survey was completed on July 9, 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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Office: 218-302-6186 Mobile: 651-279-5375

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.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245491		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/07/2026	
NAME OF PROVIDER OR SUPPLIER MOOSE LAKE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 710 SOUTH KENWOOD AVENUE , MOOSE LAKE, Minnesota, 55767			
(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 07/07/2026. At the time of this survey, Moose Lake Village 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 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us			K0000			08/05/2026

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 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. Moose Lake Village was inspected as one building. and is a 1-story building with small partial basement. The original building was constructed in 1964 and additions constructed in 1968 and 1977, all of Type II(111 construction). A single story hospital adjoins the nursing home and is separated by a 4 hour wall. To the south a single story type V(111) assisted living facility also adjoins and is separated by 4 hour construction with a 3 hour rated, self closing door. Therefore, the nursing home was inspected as one building. The facility has a capacity of 60 beds and had a census of 53 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K0000			08/05/2026
K0921 SS = F 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			K0921	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Moose Lake Village to comply with K0921 The facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities code 2012 Edition, section 10.3.		08/17/2026

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K0921 SS = F Bldg. 01	Continued from page 2 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 records review, observation, and interview, the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities Code 2012 Edition, section 10.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026 at 1:15 PM, it was revealed that the facility failed to provide documentation on the electric beds for all residents, and that PCREE such as nebulizers, oxygen concentrators, portable suction units, and other electrical medical equipment was present at the facility was inspected and maintained. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.			K0921	Continued from page 2 A detailed description of the corrective action taken or planned to correct the deficiency. Maintenance Director received training and education on PCREE. Facility obtained testing device 100% testing of all required Patient Care Electrical Equipment Address the measures put in place to ensure deficiency does not recur Added PCREE Annual testing to preventative maintenance program Add Resident owned rental equipment form to admission information Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Audit all new admissions weekly x4 and monthly x2 to ensure proper compliance with notification and testing of resident owned/rented devices. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Maintenance Director or designee		08/17/2026
K0753 SS = E Bldg. 01	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations 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.			K0753	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Moose Lake Village to comply with K0753;		08/17/2026

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K0753 SS = E Bldg. 01	Continued from page 3 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 and staff interview, the facility failed to limit flammable decorations per NFPA 101 (2012 edition), Life Safety Code, section 19.7.5.6 (4). These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/07/2026 at 11:45 AM, it was revealed by observation that room 304 had 75-80 percent of the wall surface covered with pictures and other items. 2. On 07/07/2026 at 11:45 AM, it was revealed by observation that room 315 had 60-70 percent of the wall surface covered with pictures and puzzles. 3. On 07/07/2026 at 11:45 AM, it was revealed by observation that room 210 had 50-60 percent of the wall surface covered with puzzles. An interview with the Environmental Service Director verified these deficient findings at the time of discovery.			K0753	Continued from page 3 The facility failed to limit flammable decorations per NFPA 101 (2012 edition), Life Safety Code, section 19.7.5.6(4). A detailed description of the corrective action taken or planned to correct the deficiency. Resident in room 304, 315 and 210 were educated and items removed or redistributed to ensure compliance. Address the measures put in place to ensure deficiency does not recur 100% audit of all resident room wall surfaces to ensure compliance Maintenance Director, Activities Director and Administrator were provided education Residents were educated in resident council by Activities Director. Letter sent to Resident Families with education around wall decorations. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The Activity Director or designee, will audit wall decorations in resident rooms weekly x 4 and monthly for three months to ensure limited decorations on wall. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Activity Director or designee		08/17/2026



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Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 27, 2026

Administrator

MOOSE LAKE VILLAGE

710 SOUTH KENWOOD AVENUE

MOOSE LAKE, MN 55767

Re: State Nursing Home Licensing Orders

Event ID: 235F47-H1

Dear Administrator:

The above facility survey was completed on July 9, 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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Office: 218-302-6186 Mobile: 651-279-5375

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.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 18, 2026

Administrator
MOOSE LAKE VILLAGE
710 SOUTH KENWOOD AVENUE
MOOSE LAKE, MN 55767

RE: CCN: 245491
Cycle Start Date: September 14, 2026

Dear Administrator:

On September 14, 2026, the Minnesota Department(s) 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 cursive script that reads 'Sarah Lane'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 18, 2026

Administrator
MOOSE LAKE VILLAGE
710 SOUTH KENWOOD AVENUE
MOOSE LAKE, MN 55767

Re: Reinspection Results
Event ID: 235F47-H2

Dear Administrator:

On September 14, 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 9, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

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

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245491		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER MOOSE LAKE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 710 SOUTH KENWOOD AVENUE , MOOSE LAKE, Minnesota, 55767			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0000	Initial Comments On 7/6/26 to 7/9/26, 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 7/6/26 to 7/9/26, a standard recertification survey (S# S5491041-0) 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: H54913071C (iQIES #3034963),H54913072C (iQIES #3019229), H54913074C (iQIES #2688259), H54913073C (iQIES #2995694). 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			
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)			F0812			

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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F0812 SS = F	Continued from page 1 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure minimum dishwasher temperatures were attained during the rinse cycle for 1 of 1 dishwasher. This had the potential to affect all current residents, as well as staff or visitors, who ate food served from dishes and tableware that were cleaned in the dishwasher. Findings include: During an observation on 7/6/26 at 1:58 p.m., the dishwasher wash cycle reached 153 degrees Fahrenheit (F) and the final rinse cycle reached 150 degrees F per the temperature gauges on the machine. A manufacturer sign posted next to the dishwasher instructed the final rinse cycle range should be 180-195 degrees F. During an interview on 7/6/26 at 1:58 p.m., culinary director (CD) indicated the dishwasher was a high temperature machine and stated the final rinse cycle must reach 180 degrees F. CD confirmed the low temperature and stated they needed to call the dishwasher company for service. During an interview on 7/9/26 at 9:25 a.m., the infection preventionist (IP) expected the dishwasher temperature to be hot enough to prevent the spread			F0812			

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F0812 SS = F	Continued from page 2 of any infectious materials. They stated if the dishwasher was not temping correctly, staff should report it to their supervisor or CD. During an interview on 7/9/26 at 9:46 a.m., the administrator expected the dishwasher temperature to be hot enough to sanitize dishes. They stated if the dishwasher was not reaching the correct temperature, staff should stop using the dishwasher and report it to their supervisor or CD so they could call the company that services it. Dishmachine Temperature Log dated 7/2026, the rinse temperature was logged at less than 180 degrees F for lunch use on 7/3/26 and for dinner use on 7/2/26, 7/3/26, and 7/7/26 with no indications of temperature correction. Sanitation policy revised 1/10/25, instructed the dishwasher rinse temperature specification was 180 degrees F, and if temperatures specifications were not reached, culinary staff was to stop using the machine immediately, contact their supervisor, and begin manually washing dishes.			F0812			
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can			F0761			

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F0761 SS = E	Continued from page 3 be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure medication refrigerators were kept within the recommended temperature range for 1 of 2 medication refrigerators. This deficient practice had the potential to affect any resident who received medications stored in the refrigerator. Findings include: During an observation on 7/7/26 at 2:07 p.m., the medication refrigerator in the main medication storage room had a reading of 42 degree's Fahrenheit (F). The medication log for July documented the last reading recorded as 39 degrees F. There were no temperatures recorded for July 1, 2, 3, 4, 6. The temperature log identified the safe range as 32 degrees to 41 degrees F (staff were using the food refrigerator temperature logs). Instructions identified staff were to report to the supervisor any time the temperature was out of range. Licensed practical nurse (LPN)-A verified the temperature for July was recorded only one time during July. A review of the medication temperatures for the past four months identified the following: -June there were only four temperatures recorded. There were 26 days were temperatures were not recorded. -The facility was unable to produce any temperature readings for the month of May. -The temperature readings for April had three readings recorded, with 28 days with no temperature readings recorded. A record of the medications in the refrigerator was as follows: R3, Lantus (long-acting insulin) and Trulicity (GLP-1 receptor lowers blood sugar) R62, Lantus and NovoLog (fast-acting man-made insulin) R32, Lantus, NovoLog, Trulicity R52, calcitonin spray (treats osteoporosis), Evenity (treats osteoporosis)			F0761			

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F0761 SS = E	Continued from page 4 R60, Humalog (fast-acting man-made insulin) and Lantus R45, Lantus and NovoLog R17, Lantus R31, Lantus, Basaglar (long-acting insulin) and NovoLog R37, Humalog vials Stock medications; Aplisol (diagnostic skin test to detect tuberculosis), Engerix B (vaccination to prevent hepatitis B virus), and Comirnaty (vaccine to prevent coronavirus). During an interview on 7/7/26 at 2:10 p.m., the director of nursing (DON) stated the concern was if the temperatures were too hot or too cold, it had the potential to “ruin” the medications. The DON stated she would expect staff to check refrigerator temperatures daily. During an interview on 7/8/26 at 10:31 a.m., LPN-B stated she knew there was an “issue” with the medication refrigerator temperatures, so she checked the medication refrigerator temperature in the main medication refrigerator at around 7:15 a.m., and noted the temperature was about was 50 degrees F. The medications were moved to a different refrigerator. During an interview on 7/8/26 at 12:43 p.m., the consultant pharmacist (CP)-G stated once the medication refrigerator exceeds the safe temperature all insulins should be dated as opened. CP-G stated the medication refrigerator should be between 36-46 degrees F. CP-G looked up all of the medications on the list and gave the following information: -Trulicity okay for 14 days -calcitonin spray would be okay for 35 days -Evenity would be okay for 30 days -Aplisol should be disposed of once out of the safe range -Enerix-B would be okay for seven days -Comirnaty would be okay for 12 hours CP-G stated he would start counting the hours and			F0761			

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F0761 SS = E	Continued from page 5 days as when the last known temperature was recorded.			F0761			
F0880 SS = E	The Medication Storage policy dated 6/30/23, identified nursing staff would be responsible for maintaining medication storage in a clean, safe, and sanitary environment. The policy further identified the refrigerator temperatures would be maintained between 36-46 degrees F.			F0880			
	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245491		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
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F0880 SS = E	Continued from page 6 (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that all staff (including outside contracted staff) wear appropriate personnel protective equipment (PPE) and perform appropriate hand hygiene while completing wound care on a resident. This affected 1 of 1 (R60) residents reviewed for infection control. The facility also failed to change oxygen tubing timely to decrease the risk of infection for 1 of 1 (R37) reviewed for respiratory care. Findings Include: Wound Care: R60's quarterly Minimum Data Set (MDS) dated			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245491		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
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F0880 SS = E	Continued from page 7 6/8/26, indicated R60 had intact cognition. Diagnoses included peripheral vascular disease. Section M indicated R60 was at risk for pressure ulcers/injuries and had one stage two pressure ulcer that was not present on admission. R 60 also had one open lesion that was not a pressure ulcer, rash or cut. R60's infectious disease progress note dated 7/6/26, indicated R60 had an ulceration to the abdominal wall. On 11/6/26 at 3:48 p.m., a contact precautions sign was observed on R60's door frame, outside the room. The sign stated providers and staff must clean their hands, put on gloves, a gown, and use either dedicated equipment or disposable equipment. Clean and disinfect reusable equipment before us on another person. R8's quarterly MDS dated 4/25/26, indicated R8 had intact cognition. Diagnoses included anemia, heart failure and osteomyelitis in the sacral area. Section M indicated R8 was at risk for pressure ulcers and had a stage 4 pressure ulcer. On 11/6/26 at 4:18 p.m. an Enhanced Barrier Precautions (EBP) sign was observed on R8's doorframe before entering room. The sign stated providers, and staff must perform hand hygiene, wear gloves and gown when performing high contact resident care activities such as performing wound care: any skin opening requiring a dressing. During an observation on 7/8/26 at 9:03 a.m., three members of the contracted wound care clinic staff member (WCCSM)-D, wound care clinic registered nurse (WCCRN)-B, and wound care clinic medical doctor (WCCMD) approached R60s room, along with facility licensed practical nurse (LPN)-C. LPN-C washed her hands and then placed a gown and gloves on. WCCSM-D and WCCRN-B entered R60's room without placing appropriate PPE on and raised R60's bed and touched R60's bedding and other items in the room. WCCM-D and WCCRN-B then left R60's room. LPN-B then requested WCCRN-B to place PPE on and handed a gown to her. LPN-B also requested WCCSM-D and WCCMD place appropriate PPE on since the resident was on contact precautions. WCCRN-B placed gown and gloves on at that time and then handed WCCMD and			F0880			

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F0880 SS = E	Continued from page 8 WCCSM-D a gown. WCCMD asked what the gown was for and WCCSM-D stated, “this is what they do here for wounds”. WCCSM-D and WCCMD then proceeded into R60’s room without placing PPE on. WCCMD stood at the foot of the bed, his clothing contacting the bedding and footboard, and next to the wound care cart. WCCRN stood to the right of the resident, and WCCSM-D sat next to the left side of R60, the same side of the abdominal wound. WCCRN-B held R60’s abdominal fold out of the way while WCCSM-D removed R60’s old dressing, performed measurements of the wound and applied a new dressing. All was done without changing gloves or performing hand hygiene after going from dirty to clean. While the abdominal wound was exposed WCCRN-B released the abdominal fold with the right hand, ungloved the right hand, reached into the wound cart with the ungloved, unwashed hand and grabbed a sterile package, opened the package and then handed it to WCCMD. WCCMD then proceeded to lean over R60’s bedding, coming in contact and obtained a sample from the wound. All staff then left the room, removing what PPE they had on and performed hand hygiene. WCCSM-D, WCCRN-B and WCCMD then proceeded to walk into R8’s room, without placing a gown on to perform wound care. WCCMD stopped surveyor from entering room while wound care was performed. During an interview on 7/8/26 at 9:13 a.m., LPN-B stated the other three members doing wound care were the contracted wound care providers for the facility. LPN-B stated the request was made for all three to place gown and gloves on prior to entering the rooms but WCCSM-D and WCCMD ignored the request and entered the room with only gloves on, instead of the gown and gloves as required. R60 had Methicillin-Resistant Staphylococcus aureus (a contagious staph infection that has become resistant to many common antibiotics) and LPN-B stated the infection preventionist and director of nursing should have been notified when WCCMD and WCCSM-D refused to place a gown on prior to going into the isolation rooms. When WCCSM-D, WCCRN-B, and WCCMD left R8’s room they were requested to answer questions. WCCRN-B and WCCMD kept walking towards the front door and refused to answer questions. WCCSM-D did stop, provided her first name and stated, “we don’t work for the facility”. All three WCC staff members left without answering questions.			F0880			

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F0880 SS = E	Continued from page 9 Oxygen Tubing: R37's admission Minimum Data Set (MDS) dated 6/4/26, indicated R37 was cognitively intact. Diagnoses included chronic obstructive pulmonary disorder (COPD) and sleep apnea (OCA). The MDS indicated R37 had oxygen therapy and non-invasive ventilation (use of continuous positive airway pressure (CPAP) machine). R37's care plan dated 5/29/26 indicated an altered respiratory status due to COPD and OSA. Interventions included oxygen therapy as ordered and CPAP. R37's Physician Order Report dated 6/9/26 to 7/9/26, indicated orders for CPAP, use home settings and use 2.5 liters(L) of oxygen with humidity. R37 also received oxygen at 1 to 2.5 L as needed. The orders lacked any orders to change oxygen tubing with a time limit. On 7/6/26 at 2:34 p.m., long dark green oxygen tubing was observed connect to the liquid oxygen compressor and ran to R37's CPAP machine. There was no label indicating the last time the oxygen tubing had been changed. During an interview on 7/6/26 at 2:36 p.m., R37 stated the facility had not changed the oxygen tubing going to his CPAP since he had been admitted about a month prior. R37 stated the current tubing had been provided to the facility by the resident due to having an extra and the staff used it instead of getting one out of supply. During an interview on 7/8/26 at 10:34 a.m., licensed practical nurse (LPN)-A stated all oxygen tubing was changed on a weekly basis, the date was based on when the resident was admitted. An order would be placed by the health unit coordinator so the nursing staff was aware the tubing needed to be changed weekly, and the nursing staff would acknowledge the order every time the tubing was changed. The facility did not date the tubing so the only way to know when the tubing was last changed would be based on the actual tubing change order. LPN-A reviewed R37's orders and confirmed there were no orders to change the oxygen tubing weekly,			F0880			

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F0880 SS = E	Continued from page 10 so LPN-A was unsure when R37's oxygen tubing was changed last. During an interview on 7/9/26 at 9:37 a.m., the director of nursing (DON) stated an expectation that all staff, including contracted staff, would wear the appropriate PPE and perform hand hygiene correctly when doing wound care. There also was an expectation that oxygen tubing would be changed weekly and documented as such. During an interview on 7/9/26 at 10:20 the infection preventionist (IP) stated wearing the appropriate PPE and performing hand hygiene when going from dirty to clean wound care steps were important to prevent the increased risk of spreading infection to other residents in the facility. Changing oxygen tubing weekly was important to decrease the risk of infection for the resident's using oxygen. Oxygen and humidified air cause increased moisture which can harbor infection bearing bacteria. Facility policy Personal Protective Equipment last reviewed 7/2/25, indicated PPE appropriate to specific task requirements were always available. All staff (Center for Disease Control (CDC), and Center for Medicare and Medicaid (CMS) define to include contracted staff providing care in the facility) were required to wear the correct PPE (gowns, gloves, masks) when providing certain care and when certain levels of isolation were reached. Facility policy Oxygen, portable liquid tanks last reviewed 2/18/26, indicated oxygen tubing would be replaced weekly or more frequently if needed. The weekly changes would be documented in the EHR.			F0880			
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to complete a Self-Administration of Medication (SAM) assessment and acquire a physician order for self-administration for 1 of 1 resident (R72) who was observed to have			F0554			

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F0554 SS = D	Continued from page 11 medications left at bedside. Findings include: R72's Brief Interview for Mental Health performed on admission indicated moderate cognitive impairment. R72's electronic medical record (EMR) indicated diagnoses of urinary tract infection and chronic obstructive pulmonary disease. The EMR Lacked a SAM assessment or orders to keep medications at bedside. R72's care plan undated lacked a care plan related to ability to self-administer medications On 7/6/26 at 3:05 p.m., medications including nystatin cream and refresh eye drops were observed in a pink wash basin on the counter in R72's room. On 7/7/26 at 1:21 p.m., nystatin cream, refresh eye drops, and diclofenac cream were observed in the pink basin in R72's room. On 7/8/26 at 10:32 a.m. nystatin cream, refresh eye drops, and diclofenac cream were again observed in the pink basin on the counter in R72's room. During an interview on 7/8/26 at 10:34 a.m., licensed practical nurse (LPN)-A stated prior to leaving medications at bedside a SAM assessment needed to be completed and orders received. The registered nurse did the SAM assessments usually a week after admission so the staff could get a good understanding of cognition and if it would be safe to leave medications at bedside and for the residents to self-administer medications. Before the week was up all medications were to be kept in the nurse's medication cart. R72 was admitted on Thursday 7/2/26, so the SAM would not be completed until around Thursday 7/9/26. LPN-A looked in R72's room and confirmed the nystatin cream, refresh eye drops, and diclofenac cream were in the room. LPN-A reviewed R72's EMR and confirmed there was no SAM assessment completed for R72. During an interview on 7/8/26 at 2:46 p.m., registered nurse (RN)-A stated the RN's would do the SAM assessments. Most SAM assessments were done about a week after admission, unless the			F0554			

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F0554 SS = D	Continued from page 12 resident requested, then they were completed quicker. A week gave the staff time to get a good understanding of cognition level. During an interview on 7/9/26 at 9:37 a.m., the director of nursing (DON) stated the expectation was the SAM assessment would be completed prior to medications being left at bedside. Facility policy Self Administration of Medication last reviewed 9/30/25, indicated a SAM assessment would be performed at admission and orders obtained, if approved, prior to medications left in the room. The care plan would also be updated, adding the SAM assessment to the care plan.			F0554			
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure orders for blood sugar readings were followed for 1 of 5 residents (R19) reviewed for unnecessary medications. Findings include: R19's Face Sheet dated 7/9/26, identified he had diagnoses which included chronic heart failure (a chronic progressive condition where the heart muscle does not pump blood effectively), recurrent dislocation of right shoulder, type 2 diabetes mellitus with diabetic neuropathy, and hypertension. R19's admission Minimum Data Set dated 4/8/26, identified he was cognitively intact, had no rejections of care, and required substantial assistance with activities of daily living. R19's care plan identified he was at risk for a decline in medical condition related to diabetes mellitus. Interventions included to administer medications and treatments per the medical doctor's			F0684			

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F0684 SS = D	Continued from page 13 order. R19's Physician Order Report dated 6/1/26, identified the following: "Test blood sugars QID (four times a day), before meals, and prior to bedtime. Special Instructions: Contact Hospice if blood sugar 450 or higher. Under 70 treat with juice and recheck 1 hour after." A review of R19's vital sign report identified the following: 6/2/26 at 7:55 a.m., blood sugar reading was 62 6/2/26 at 9:55 a.m., over one hour later the reading was 230 6/6/26 at 7:56 a.m., blood sugar reading was 68 6/6/26 at 12:24 p.m., over one hour later the reading was 175 6/7/26 at 6:43 a.m., blood sugar reading was 61 6/7/26 at 9:18 a.m., over one hour later the reading was 159 6/14/26 at 5:44 p.m., blood sugar reading was 500 A review of R19's June 2026 progress notes did not identify a note indicating hospice had been called on 6/14/26, about the blood sugar reading. 6/15/26 at 5:53 p.m., blood sugar reading was 453 A review of R19's June 2026 progress notes did not identify a note indicating hospice had been called on 6/15/26, about the blood sugar reading. 6/28/26 at 5:50 p.m., blood sugar reading was 516 A progress note dated 6/29/26 at 2:37 p.m., identified they notified hospice staff in person of "recent" blood sugar. 7/9/26 at 6:35 a.m., blood sugar reading was 65 7/9/26 at 8:29 a.m., over one hour later the blood sugar reading was 158 During an interview on 7/6/26 at 2:09 p.m., R19 expressed concerns about having low blood sugars in the morning. During an interview on 7/8/26 at 10:53 a.m., registered nurse (RN)-C with hospice stated he had			F0684			

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F0684 SS = D	Continued from page 14 been very involved with his care and would speak up about what his needs were. RN-C stated she would expect the staff to follow the orders for blood sugars and recheck R19's blood sugar in one hour to ensure his blood sugar was coming up and to ensure it was trending downward. RN-C stated she would also expect them to follow the order to notify hospice when the blood sugar was greater than 450. During an interview on 7/8/26 at 11:47 a.m., licensed practical nurse (LPN)-C reviewed R19's orders and verified the order specified if the blood sugar was less than 70, they needed to give juice and recheck the blood sugar in one hour. LPN-C stated it was important to follow the order to ensure the blood sugar wasn't staying low. LPN-C stated the order also specified the order included to notify hospice if the blood sugar was 450 or higher. During an interview on 7/9/26 at 8:22 a.m., LPN-D stated when R19's blood sugar was low, they were supposed to recheck his blood sugar in one hour. LPN-D stated they needed to make sure the blood sugar was coming up and not going lower. During an interview on 7/9/26 at 9:24 a.m., the director of nursing (DON) stated when a blood sugar was low staff needed to get the blood sugar up. The DON stated it was important for staff to follow orders as written. The DON stated if the blood sugar was too low the resident could have cognition changes, potential for falls, confusion, and/or sedation. If the resident refused the recheck, she would expect staff to document the refusal. The Hypoglycemia management policy dated 11/21/19, identified the objective was to identify hypoglycemia and restore normal blood sugar as quickly as possible. Steps identified to take included to treat hypoglycemia promptly and follow the protocol, report and document the episode.			F0684			

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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 7/6/26 to 7/9/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H54913071C (iQIES #3034963),H54913072C (iQIES #3019229), H54913074C (iQIES #2688259),			20000			

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 H54913073C (iQIES #2995694). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational 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			
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 I Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as			20875			

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20875	Continued from page 3 6/14/26, about the blood sugar reading. 6/15/26 at 5:53 p.m., blood sugar reading was 453 A review of R19's June 2026 progress notes did not identify a note indicating hospice had been called on 6/15/26, about the blood sugar reading. 6/28/26 at 5:50 p.m., blood sugar reading was 516 A progress note dated 6/29/26 at 2:37 p.m., identified they notified hospice staff in person of "recent" blood sugar. 7/9/26 at 6:35 a.m., blood sugar reading was 65 7/9/26 at 8:29 a.m., over one hour later the blood sugar reading was 158 During an interview on 7/6/26 at 2:09 p.m., R19 expressed concerns about having low blood sugars in the morning. During an interview on 7/8/26 at 10:53 a.m., registered nurse (RN)-C with hospice stated he had been very involved with his care and would speak up about what his needs were. RN-C stated she would expect the staff to follow the orders for blood sugars and recheck R19's blood sugar in one hour to ensure his blood sugar was coming up and to ensure it was trending downward. RN-C stated she would also expect them to follow the order to notify hospice when the blood sugar was greater than 450. During an interview on 7/8/26 at 11:47 a.m., licensed practical nurse (LPN)-C reviewed R19's orders and verified the order specified if the blood sugar was less than 70, they needed to give juice and recheck the blood sugar in one hour. LPN-C stated it was important to follow the order to ensure the blood sugar wasn't staying low. LPN-C stated the order also specified the order included to notify hospice if the blood sugar was 450 or higher. During an interview on 7/9/26 at 8:22 a.m., LPN-D stated when R19's blood sugar was low, they were supposed to recheck his blood sugar in one hour. LPN-D stated they needed to make sure the blood sugar was coming up and not going lower. During an interview on 7/9/26 at 9:24 a.m., the director of nursing (DON) stated when a blood sugar was low staff needed to get the blood sugar up. The DON stated it was important for staff to follow orders as written. The DON stated if the blood sugar was too low the resident could have cognition			20875			

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20875	Continued from page 4 changes, potential for falls, confusion, and/or sedation. If the resident refused the recheck, she would expect staff to document the refusal. The Hypoglycemia management policy dated 11/21/19, identified the objective was to identify hypoglycemia and restore normal blood sugar as quickly as possible. Steps identified to take included to treat hypoglycemia promptly and follow the protocol, report and document the episode. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff followed all orders as written. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20875			
21015	Dietary Staff Requirements- Sanitary conditi CFR(s): MN Rule 4658.0610 Subp. 7 Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure minimum dishwasher temperatures were attained during the rinse cycle for 1 of 1 dishwasher. This had the potential to affect all current residents, as well as staff or visitors, who ate food served from dishes and tableware that were cleaned in the dishwasher. Findings include: During an observation on 7/6/26 at 1:58 p.m., the dishwasher wash cycle reached 153 degrees Fahrenheit (F) and the final rinse cycle reached 150 degrees F per the temperature gauges on the machine. A manufacturer sign posted next to the dishwasher instructed the final rinse cycle range should be 180-195 degrees F. During an interview on 7/6/26 at 1:58 p.m., culinary			21015			

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21015	Continued from page 5 director (CD) indicated the dishwasher was a high temperature machine and stated the final rinse cycle must reach 180 degrees F. CD confirmed the low temperature and stated they needed to call the dishwasher company for service. During an interview on 7/9/26 at 9:25 a.m., the infection preventionist (IP) expected the dishwasher temperature to be hot enough to prevent the spread of any infectious materials. They stated if the dishwasher was not temping correctly, staff should report it to their supervisor or CD. During an interview on 7/9/26 at 9:46 a.m., the administrator expected the dishwasher temperature to be hot enough to sanitize dishes. They stated if the dishwasher was not reaching the correct temperature, staff should stop using the dishwasher and report it to their supervisor or CD so they could call the company that services it. Dishmachine Temperature Log dated 7/2026, the rinse temperature was logged at less than 180 degrees F for lunch use on 7/3/26 and for dinner use on 7/2/26, 7/3/26, and 7/7/26 with no indications of temperature correction. Sanitation policy revised 1/10/25, instructed the dishwasher rinse temperature specification was 180 degrees F, and if temperatures specifications were not reached, culinary staff was to stop using the machine immediately, contact their supervisor, and begin manually washing dishes. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21015			

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21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to complete a Self-Administration of Medication (SAM) assessment and acquire a physician order for self-administration for 1 of 1 resident (R72) who was observed to have medications left at bedside. Findings include: R72's Brief Interview for Mental Health performed on admission indicated moderate cognitive impairment. R72's electronic medical record (EMR) indicated diagnoses of urinary tract infection and chronic obstructive pulmonary disease. The EMR Lacked a SAM assessment or orders to keep medications at bedside. R72's care plan undated lacked a care plan related to ability to self-administer medications On 7/6/26 at 3:05 p.m., medications including nystatin cream and refresh eye drops were observed in a pink wash basin on the counter in R72's room. On 7/7/26 at 1:21 p.m., nystatin cream, refresh eye drops, and diclofenac cream were observed in the pink basin in R72's room. On 7/8/26 at 10:32 a.m. nystatin cream, refresh eye drops, and diclofenac cream were again observed in the pink basin on the counter in R72's room. During an interview on 7/8/26 at 10:34 a.m., licensed practical nurse (LPN)-A stated prior to leaving medications at bedside a SAM assessment needed to be completed and orders received. The registered nurse did the SAM assessments usually a week after admission so the staff could get a good understanding of cognition and if it would be safe to leave medications at bedside and for the residents to self-administer medications. Before the week was up all medications were to be kept in the nurse's			21565			

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21565	Continued from page 7 medication cart. R72 was admitted on Thursday 7/2/26, so the SAM would not be completed until around Thursday 7/9/26. LPN-A looked in R72's room and confirmed the nystatin cream, refresh eye drops, and diclofenac cream were in the room. LPN-A reviewed R72's EMR and confirmed there was no SAM assessment completed for R72. During an interview on 7/8/26 at 2:46 p.m., registered nurse (RN)-A stated the RN's would do the SAM assessments. Most SAM assessments were done about a week after admission, unless the resident requested, then they were completed quicker. A week gave the staff time to get a good understanding of cognition level. During an interview on 7/9/26 at 9:37 a.m., the director of nursing (DON) stated the expectation was the SAM assessment would be completed prior to medications being left at bedside. Facility policy Self Administration of Medication last reviewed 9/30/25, indicated a SAM assessment would be performed at admission and orders obtained, if approved, prior to medications left in the room. The care plan would also be updated, adding the SAM assessment to the care plan. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should review and revise policies for self-administration of medication according to evidence-based practices/procedures. Nursing staff should be educated as necessary to the importance of ensuring the resident is deemed capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff should also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, should audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee should take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21565			
21610	Medicine Cabinet and Preparation Area;Storage CFR(s): MN Rule 4658.1340 Subp. 1			21610			

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21610	Continued from page 8 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure medication refrigerators were kept within the recommended temperature range for 1 of 2 medication refrigerators. This deficient practice had the potential to affect any resident who received medications stored in the refrigerator. Findings include: During an observation on 7/7/26 at 2:07 p.m., the medication refrigerator in the main medication storage room had a reading of 42 degree's Fahrenheit (F). The medication log for July documented the last reading recorded as 39 degrees F. There were no temperatures recorded for July 1, 2, 3, 4, 6. The temperature log identified the safe range as 32 degrees to 41 degrees F (staff were using the food refrigerator temperature logs). Instructions identified staff were to report to the supervisor any time the temperature was out of range. Licensed practical nurse (LPN)-A verified the temperature for July was recorded only one time during July. A review of the medication temperatures for the past four months identified the following: -June there were only four temperatures recorded. There were 26 days were temperatures were not recorded. -The facility was unable to produce any temperature readings for the month of May. -The temperature readings for April had three readings recorded, with 28 days with no temperature readings recorded. A record of the medications in the refrigerator was as follows: R3, Lantus (long-acting insulin) and Trulicity (GLP-1 receptor lowers blood sugar) R62, Lantus and NovoLog (fast-acting man-made insulin)			21610			

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21610	Continued from page 9 R32, Lantus, NovoLog, Trulicity R52, calcitonin spray (treats osteoporosis), Evenity (treats osteoporosis) R60, Humalog (fast-acting man-made insulin) and Lantus R45, Lantus and NovoLog R17, Lantus R31, Lantus, Basaglar (long-acting insulin) and NovoLog R37, Humalog vials Stock medications; Aplisol (diagnostic skin test to detect tuberculosis), Engerix B (vaccination to prevent hepatitis B virus), and Comirnaty (vaccine to prevent coronavirus). During an interview on 7/7/26 at 2:10 p.m., the director of nursing (DON) stated the concern was if the temperatures were too hot or too cold, it had the potential to “ruin” the medications. The DON stated she would expect staff to check refrigerator temperatures daily. During an interview on 7/8/26 at 10:31 a.m., LPN-B stated she knew there was an “issue” with the medication refrigerator temperatures, so she checked the medication refrigerator temperature in the main medication refrigerator at around 7:15 a.m., and noted the temperature was about was 50 degrees F. The medications were moved to a different refrigerator. During an interview on 7/8/26 at 12:43 p.m., the consultant pharmacist (CP)-G stated once the medication refrigerator exceeds the safe temperature all insulins should be dated as opened. CP-G stated the medication refrigerator should be between 36-46 degrees F. CP-G looked up all of the medications on the list and gave the following information: -Trulicity okay for 14 days -calcitonin spray would be okay for 35 days -Evenity would be okay for 30 days -Aplisol should be disposed of once out of the safe range -Enerix-B would be okay for seven days			21610			

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21610	Continued from page 10 -Comirnaty would be okay for 12 hours CP-G stated he would start counting the hours and days as when the last known temperature was recorded. The Medication Storage policy dated 6/30/23, identified nursing staff would be responsible for maintaining medication storage in a clean, safe, and sanitary environment. The policy further identified the refrigerator temperatures would be maintained between 36-46 degrees F. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure medication refrigerators were checked daily and actions taken when out of range. In addition, to ensure the correct temperature monitoring chart was used for medication refrigerators. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21610			