



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 1, 2026

Administrator
THE EMERALDS AT ST PAUL LLC
420 MARSHALL AVENUE
SAINT PAUL, MN 55102

RE: CCN: 245295
Cycle Start Date: August 19, 2026

Dear Administrator:

On August 19, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically 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:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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 November 19, 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 February 19, 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,

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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September 1, 2026

Administrator

THE EMERALDS AT ST PAUL LLC

420 MARSHALL AVENUE

SAINT PAUL, MN 55102

Re: State Nursing Home Licensing Orders

Event ID: 284EE2-H1

Dear Administrator:

The above facility survey was completed on August 19, 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:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/19/2026	
NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT ST PAUL LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(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 8/16/26 to 8/19/26, a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.			E0000			09/08/2026
F0000	INITIAL COMMENTS On 8/16/26 to 8/19/26, a standard recertification survey (S5295040-0) 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 with NO deficiencies were cited: H52953757C (3124686) H52953758C (3104887) H52953759C (3083785) H52953764C (3066949) H52953767C (3066891) H52953760C (3050523) H52953761C (3042456) H52953765C (3032530)			F0000			

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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F0000	Continued from page 1 H52953763C (3025002) H52953766C (3020854) H52953768C (3010628) H52953769C (3002245) H52953770C (2995646) H52953771C (2985315) H52953772C (2747696) H52953776C (2737176) H52953773C (2642814) H52953774C (1111629, MN00105915) 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			09/08/2026
F0925 SS = G	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure repair recommendations from an outside pest control contractor were acted upon and completed timely to reduce the risk of rodent entry into the care center. In addition, the facility failed to follow Centers for Disease Control (CDC) recommended pest control procedures to ensure potential rodent entry points (i.e., holes in resident walls) were sealed, which had the potential to affect all 88 residents residing in the			F0925	R30 has been discharged from the facility as of 8/19/2026. All current residents have the potential to be affected by this deficient practice. Facility maintenance team completed a room audit of all rooms in the facility for holes that could be an entry point for mice. The maintenance team completed repairs on all identified Plunkett's recommendations. All nursing staff have been educated on the TELs submission process for reporting resident rooms that contain holes that may require repair. Maintenance director was educated on completing all identified Plunkett's recommendations and/or have an identified timeline for completion within 30 days of report receipt.		10/05/2026

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F0925 SS = G	Continued from page 2 facility. This caused actual harm to R30 when a potential rodent sighting caused psychosocial distress (i.e., crying, moaning, restlessness, agitation). Findings include: A CDC Controlling Wild Rodent Infestations article dated 4/8/24, indicated rodents were known to carry various diseases which could be spread to a human population. These diseases included salmonellosis, monkeypox, and tularemia. Further, the article indicated it was important to seal gaps or holes in exterior walls, adding, "mice can fit through a hole the width of a pencil (1/4 inch or 6 millimeters in diameter)." A CDC How to Seal Up to Prevent Rodents article dated 4/8/24, indicated that it was important to check inside your home for gaps or holes such as around windows, doors, “pipes leading to water heaters and furnaces”, behind appliances, around the pipes under sinks, around all water and sewer lines, etc. The article indicated that any holes you find should be sealed to prevent rodents from entering and recommended that small holes be filled with steel wool and then caulked/spray-foamed in place. The article also indicated that if a larger hole was found, a lath (steel) screen, cement, hardware cloth, or metal sheeting should be used to cover/fill it. R30 R30’s significant change MDS dated 7/27/26, indicated R30 had admitted to the facility on 6/1/26 and had severely impaired cognition. The MDS indicated R30 was dependent on staff for all activities of daily living (ADLs) and was receiving hospice care and tracheostomy care. The MDS did not include a complete resident mood interview. The MDS did not include a diagnosis of anxiety. The MDS indicated R30 was admitted to the facility on 6/1/26 and resided in room 427. R30’s care plan dated 8/12/26, indicated R30 was diagnosed with respiratory failure, malnutrition, and a stroke. The care plan also indicated that R30 had quadriplegia (affects a person’s ability to deliberately control or move body parts from the neck down) and used a tracheostomy (a surgical hole in the front of the neck used to help with breathing) tube. The care plan's included diagnosis list did not reference anxiety. The care plan indicated R30 was completely dependent on a tube feeding for his nutrition and hydration support and was			F0925	Continued from page 2 Maintenance Director and/or designee will audit TELs weekly to verify that any identified holes are patched within the week. Administrator and/or designee will audit Plunkett’s reports weekly to verify repair has been completed and/or a timeline for repair has been identified. Facility will conduct audits weekly x4 weeks, and then monthly x2 months thereafter. Audit results will be reviewed through the QAPI process for compliance and additional recommendations. 10/5/2026		10/05/2026

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F0925 SS = G	Continued from page 3 receiving no food by mouth. The care plan indicated that R30 was a “categorically a vulnerable adult” and staff were to monitor for signs of emotional distress or mood/behavior changes. The care plan indicated R30 had an alteration in socialization due to “being unable to communicate”, although the resident was able to say some words and shake head to yes or no questions. The care plan indicated R30 was signed on to hospice cares on 7/20/26 with an end-stage disease process of a cerebral infarction (stroke). The care plan indicated that R30 had an alteration in cognition, so staff were to document changes in orientation, provide cues, reorientation/supervision as needed, and provide/maintain a consistent environment. R30’s medication and treatment administration record (MAR) dated 8/1/26 to 8/19/26 indicated the following: -on 7/21/26, 0.5 mg of lorazepam every four hours as needed. The as-needed lorazepam was given 14 times between 8/1/26 and 8/18/26. -on 8/11/20.5 mg of lorazepam every four hours was ordered for "terminal agitation". -target behavior monitoring was completed three times a day, with behaviors noted 10 of the 19 days. Behaviors included pulling lines for 7 of the days with interventions of reposition and redirection. The other 3 days anxiety was noted with interventions of repositioning and redirection. R30’s progress notes dated were reviewed. The note dated: -8/13/26 at 11:15 p.m., indicated that R30 had RR-A visit for the evening shift and R30 had been relaxed during the shift. -8/17/26 at 3:34 p.m., indicated R30 had no signs of pain, discomfort, or distress noted. -8/18/26 at 10:05 a.m., lorazepam was given for anxiety, “pulling”, and “hitting out”. -8/18/26 at 3:30 p.m., indicated that R30 was “pleasant, calm and cooperative with cares”. -8/18/26 at 6:07 p.m., the note indicated that RR-A had contacted the administrator related to a concern for a potential mouse. The note indicated that “tangible solutions” were discussed with RR-A. The note indicated that RR-A would like hourly checks to be completed through the evening and a room			F0925			10/05/2026

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F0925 SS = G	Continued from page 4 move tomorrow. The note indicated that a pest control company had been contacted to request a visit for tomorrow. The note indicated that a grievance form was completed and the administrator apologized for the “inconvenience”. -8/19/26 at 12:20 a.m., written by registered nurse (RN)-G, indicated that R30 was “anxious and agitated” due to his “room condition.” The note indicated that R30’s “tracheostomy” was “accidentally” removed by R30, and a new tracheostomy set was placed. The note indicated that R30 was given his scheduled medications and then rested comfortably in bed. The note indicated that R30 was monitored every hour due to “emotional distress”. -8/19/26 at 7:26 a.m., indicated that the administrator had checked on R30 during morning rounds and R30 appeared to be sleeping comfortably in bed. The note indicated R30 had no anxiousness noted at the time of the visit. The note indicated that it was explained that a room move would be completed in the afternoon when R30 was up in his wheelchair, and R30 was agreeable to the plan. -8/19/26 at 10:30 a.m., indicated that RR-A had found the administrator and stated that “he” would now like to go to the hospital related to R30’s anxiety. An undated video shown by RR-A on 8/19/26 at 9:00 a.m., included a four-legged rodent that appeared to be anywhere from five to eight inches long (as a best estimate based on surrounding items) with a long tail. The rodent was observed walking down a hallway that at the end had a window, a baseboard heater, and a white foldable chair. In the video, the rodent was walking down the hallway towards the white chair, then along the bottom of the baseboard heater before the video ended. During an interview and observation on 8/19/26 at 9:00 a.m., RR-A was observed to take his phone out and show a video of a rodent in what appeared to be the fourth-floor hallway outside of R30’s room. RR-A stated that the rat seen in the video had exited R30’s room and entered the hallway last night. RR-A stated that he believed that a rat had been found in a trap in R30’s room a few nights ago. RR-A stated that R30 had limited mobility and didn’t keep any food in the room because R30 couldn’t eat anything by mouth. RR-A stated that about a week and a half ago he saw a mouse in R30’s room and he stepped on it and killed it. RR-A			F0925			10/05/2026

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F0925 SS = G	Continued from page 5 stated that last Thursday he had spent the night witnessed another mouse in the far-left corner of the exterior wall of R30's room. RR-A stated that last night a mouse had been observed in R30's bed and that had caused a lot of anxiety for R30. RR-A claimed that the repeated rodent sightings over the last couple of weeks in the facility had caused R30 "emotional distress" and they even had to make changes to his anxiety medication. RR-A stated the facility offered to move R30 to a new room after the incident last night. RR-A stated he had contacted the hospice company to see if he could get additional resources to bring R30 home with him. R30 stated that the facility had now started to put interventions in place but felt that these interventions should have been done prior to the repeated rodent sightings. RR-A stated he was going to admit R30 to the hospital due to R30's emotional distress from the rodent presence in the building. During an observation on 8/19/26 at 9:05 a.m., R30's fourth-floor room was observed with the baseboard heating unit pipes coming through the far wall on the left-hand side of the exterior wall of the room. A hole greater than the size of a quarter was observed around the pipe's entrance into the room, and a large sticky trap by it appeared new (no dust, build-up, debris). R30 was sitting in the dining room and appeared restless/agitated as he was loudly moaning, grunting, and his brow appeared furrowed/grimaced. R30's signs of restlessness/agitation were observed to stop when RR-A walked over to him. RR-A was then seen telling R30 he was going to load the car and then he was coming back. R30, in response, made loud moaning noises and tense, grimacing facial expressions, as if upset. During an interview on 8/19/26 at 10:40 a.m., NP-A stated she had gotten a report of a rodent in the building today and sometime last month. NP-A stated that if she got a report of a rodent in a resident's room or bed, she wasn't exactly sure what she would do but would start by seeing if the resident had any changes in condition or any bites. NP-A stated that although it depended on the person, a person most likely wouldn't want a rodent in their bed or room, and it could be a "scary finding" depending on the individual. NP-A stated that if a resident has a tracheostomy tube with anxiety and agitation, there could be a potential concern for the tracheostomy tube being pulled out. NP-A stated that for R30, he did have a recent history of anxiety and restlessness, and they had been having to make medication changes for him.			F0925			10/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/19/2026	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0925 SS = G	Continued from page 6 NP-A stated that although R30 had this anxiety history, pulling out his tracheostomy tube was a change for him, as she was unaware of him doing this in the past. NP-A stated that in the past and when she visited him, he generally seemed relatively comfortable, and she had only seen him “vocal” related to possible agitation once or twice. During an interview on 8/19/26 at 10:54 a.m., RN-B stated she was R30’s nurse for the day shift. RN-B stated R30 generally didn’t have signs of anxiety or agitation for her, and she can tell when he is moaning and groaning. RN-B stated R30 did not have a history of pulling at his tracheostomy, and given his anxiety related to the mouse in his room last night, they were completing hourly checks on him today. RN-B stated she did notice anxiety in him this morning, but his anxiety seemed to escalate as the day went on and the partner was in the building. During an interview and observation on 11:02 a.m. with pest control service technician (PCST)-A and the DOM, a hole that was approximately two inches by approximately six inches around the pipes leading to the baseboard heating unit in the left-hand corner of R30's room was observed. PCST-A stated a rat could enter a resident room through a hole the size of a quarter and a mouse can get in through a hole the width of a pen. PCST-A stated that he believed this was where the rat had likely entered the resident’s room last night. PCST-A stated he would use a powder in the hole as a poison for the rats and, for now, would leave the hole open with the now unoccupied room door closed so the rat didn’t decide to enter a third-floor room instead or exit into the hallway. The DOM stated he had seen the video of a rat, and it appeared that the rat was in the fourth-floor hallway. PCST-A stated that the vines on the side of the building, even if they are treated and dead, could be used by the rats to climb and enter the building and suggested to the DOM that these be taken down. On 8/19/26 at 11:37 a.m., a call was made to the medical director with no answer and a message indicating his voicemail was full. A call was then placed at 11:38 to an office number provided by the facility, and a message was left asking for a call back. A call back was not received. During an interview on 8/19/26 at 12:01 p.m., nursing assistant (NA)-A stated she worked last evening with R30. NA-A stated that a family friend of R30 was in the room with R30 and had alerted her that they had seen a rodent in his room. NA-A			F0925			10/05/2026

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F0925 SS = G	Continued from page 7 stated she had then looked at R30, who was staring at the left-hand corner of the exterior wall of R30’s room. NA-A stated she had then examined the area. NA-A stated the area had insulation on the floor that she hadn’t noticed previously and it “looked like something had come out of the wall”. NA-A then stated that she believed that a rodent had exited the wall from that corner of the room and entered R30’s room. NA-A stated she had seen anxiety in R30 before this incident but saw “increased anxiety and agitation” after this incident and thought R30 now looked “fearful”. NA-A stated that with R30’s increased anxiety and agitation, R30 had pulled out his tracheostomy tube during the shift. NA-A stated she had elevated R30’s bed high off the floor to try to help with his anxiety, and she checked on him often during her shift after the incident. During an interview on 8/19/26 at 12:24 p.m., RN-G stated that yesterday was her first day working with R30. RN-G stated that a family member of R30 had notified her that a rodent had been in R30’s room and showed her a video of a rodent in the building. RN-G stated that when she entered R30’s room, she had noticed insulation and what appeared to be pieces of wall on R30’s floor that staff had to vacuum up. RN-G stated this had led her to believe that a rodent had entered R30’s room. RN-G stated that after this incident, R30 became “emotionally distressed” and was “moaning and crying”. RN-G stated that R30 became “agitated” and pulled his tracheostomy tube out, and she had to insert a new one. RN-G stated she gave him his scheduled anxiety medication, completed more frequent checks on him, and after the medication had time to take effect, R30 calmed down. Facility The facility’s consulted pest control company service report dated 6/30/26, indicated the following actions were required of the facility: -A continued recommendation from 4/28/25, there was a hole behind the toilet in room 414 that should be addressed by maintenance. -A continued recommendation from 6/12/25, there were holes in the bathroom in room 413 that should be patched, as it could “lead to rodents entering the room”. -A continued recommendation from 8/6/25, there were vines on the east side of the building that should be removed by staff, as rodents had been known to climb this in the past. The report included			F0925			10/05/2026

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F0925 SS = G	Continued from page 8 a picture of a brick building that appeared to be four stories with three windows, one above the other, noted. The picture included various brown vines on the building that climbed up to approximately the bottom of the second window that was visible (third-story window). -A continued recommendation from 8/6/25, there was a hole in the exterior of the building by the dumpster area, above a window to the left of a staircase. The recommendation indicated this was a potential rodent entry point, and it should be repaired as necessary. The facility's consulted pest control company service report dated 7/29/26, indicated the following action required of the facility: -A continued recommendation from 6/12/25, there was a hole in the 413 bathroom that should be patched and was too big for the consultant company to patch. The facility's consulted pest control company service report dated 8/13/26, indicated the following action required of the facility: -There were "rodent concerns in room" 415 and a "big hole" in the bathroom that needed to be filled with drywall. -There were "rodent concerns in room" 416 and a "big hole" under the sink that needed to be filled with drywall. -A continued recommendation from 8/4/26, there were "major" gaps around plumbing, with the recommendation to fill in the gap behind the toilet. The facility's consulted pest control company service report dated 8/17/26, indicated the following action required of the facility: -A continued recommendation from 8/4/26, there were "major" gaps around plumbing, with the recommendation to fill in the gap behind the toilet. R7's quarterly Minimum Data Set (MDS) dated 7/16/26, indicated R7 admitted to the facility on 4/17/26, had intact cognition, and no delusions or hallucinations during the look back period (LBP). The resident resided in room 415. During an interview and observation on 8/19/26 at 8:42 a.m., R7 sat on the edge of his bed with oxygen tubing attached to himself (over the ears and			F0925			10/05/2026

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F0925 SS = G	Continued from page 9 inserted into the nose) with extra tubing lying on the floor. R7’s bathroom was observed with a hole that was greater than the size of a quarter around each side of the pipes and was visible behind the toilet where the pipes entered the wall. R7 stated that he saw a mouse coming through the hole a week ago. R7 stated that the mouse got stuck in his oxygen tubing on his floor and he had to help it get out. R7 stated he saw mice every day in the facility but not always coming out of the hole in his bathroom. R16’s quarterly MDS dated 6/18/26, indicated R16 admitted to the facility on 3/17/26, had intact cognition, and no delusions or hallucinations during the LBP. R16 resided in room 416. During an interview on 8/16/26 at 2:22 p.m., R16 stated there was a large hole in the plaster under the sink in their room, and they had seen mice in their room in the past. R16 stated that something had bitten him in bed last night and showed two pinpoint scabs approximately two centimeters apart on his lower calf. R58’s quarterly MDS dated 6/9/26, indicated R58 admitted to the facility on 9/18/25, had intact cognition, and no delusions or hallucinations during the LBP. R58 resided in room 326. During an interview on 8/16/26 at 5:15 p.m., R58 stated that the facility had an “issue” with mice as she saw mice run across the floor in her room last month. R102’s entry tracking MDS dated 8/15/26, indicated R102 admitted to the facility on 8/15/25. An admission/comprehensive MDS with cognition data was not yet completed. R102 resided in room 417. During an interview on 8/16/26 at 1:56 p.m., R102 stated the facility was not well cared for, and nothing got fixed. R102 also expressed concern that there was ivy growing up the exterior wall outside their window. Multiple brown colored vines were observed covering R102’s fourth-floor window. During an interview and observation on 8/18/26 at 2:42 p.m., the director of maintenance (DOM) stated he was the only maintenance personnel for the building, although occasionally the regional maintenance staff member would help. The DOM stated he had started working at the facility approximately six months ago and stated that the building was “in terrible shape”. The DOM stated it was only him for the most part to complete all the maintenance for the building, and he felt that he			F0925			10/05/2026

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F0925 SS = G	Continued from page 10 didn't have enough time to complete all the tasks that were assigned to him. R16's room was observed with a hole surrounding the sink pipes that was approximately one foot by one foot. Multiple brown vines were observed adhered to the exterior of R102's window. The DOM stated that he thought the hole had been that way for "a while" and it was on his list to fix, but he didn't have enough time to finish everything. During an observation and interview on 8/19/26 at 9:14 a.m. with the DOM, -brown vines were observed as described in the 6/30/26 consultant pest control report but seemed to have expanded a couple of feet and now covered a resident window. The DOM stated he had treated the vines but thought that since they were thought to be dead, the rats would be unable to climb the vines, and it would also be a lot of work to take them down. -A hole in the exterior of the building by the dumpster area was observed, above a window to the left of a staircase, and was approximately 1.5 inches in diameter. The maintenance director stated he had been unaware of this hole, but it looked like the area needed to be filled. -An approximately inch gap around the outside of the 413-bathroom (shared with 411) toilet pipes was observed. -In 414 (shared with 412) bathroom, a hole that was at least three inches by one inch was observed behind the toilet where the pipes enter the wall. -In 415's (shared with 417) bathroom, a hole that was greater than the size of a quarter around each side of the pipes was visible behind the toilet where the pipes entered the wall. The DOM stated that he did believe that rats or mice would be able to enter the holes observed in the 413, 414, and 415 bathrooms. The DOM stated he believed that these holes had been present since at least when he started six months ago. The DOM stated that the facility had made fixes in the main kitchen as they had previously had issues with rodents entering this area. The DOM stated that, as it was mainly only him working on these fixes, he was unable to get to fixing the holes in the resident rooms due to time constraints. During an interview on 8/19/26 at 2:23 p.m., the administrator stated the building previously didn't have a "great" maintenance structure. The			F0925			10/05/2026

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F0925 SS = G	Continued from page 11 administrator stated that since the current DOM took over, he had been patching holes, they completed maintenance on the kitchen, were completing monthly building plant tours, and redid a walkway. The administrator stated the facility had “a lot” of things that still needed to be done, but the facility had made “a lot” of improvements since the DOM started. The administrator stated the DOM had been the sole person completing the maintenance on the building with occasional help from the regional maintenance staff member. The DOM stated the facility depended on corporate approval for getting additional resources such as staff for completing maintenance projects. The administrator stated she had been made aware of a potential rodent from RR-A and had ensured more frequent monitoring was completed on R30. The administrator stated she had gone up today to check on R30 and felt that R30 was not showing any anxiety or agitation at that time. The administrator stated she had offered a room change to RR-A. The administrator stated that at first RR-A was agreeable to this, but then RR-A's anxiety was “out of control” and R30 ended up transferring to the hospital. The administrator stated she felt like RR-A's anxiety led to an increase in R30's anxiety. The administrator stated that she felt that R30's anxiety was caused by multiple factors and did not feel it could be attributed to the rodents in the building. A Policy regarding pest control was requested and not received.			F0925			10/05/2026
E0032 SS = F	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.542(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following:			E0032	Facility emergency preparedness book was updated with a personalized communication policy that included alternative forms of communication. All residents and staff have the potential to be affected by this deficient practice. Residents and staff were offered a copy of the communication policy for review. The facility administrator was educated on reviewing emergency preparedness policies annually to ensure that all policies remain current and are up to date within the binder. Administrator and/or designee will audit the facility communication policy weekly x4 weeks to ensure that it remains in the binder and is up to date. Facility will then audit annually thereafter. Audit results will be reviewed through the QAPI process for		10/05/2026

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E0032 SS = F	Continued from page 12 (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Preparedness Plan (EPP) included a communication plan that is individualized to facility that includes an alternative form of communication. This had the potential to affect all 88 residents in the facility as well as staff who worked there. Findings Include: The facility's EPP dated 3/2026, specified emergency numbers, however lacked an individuated communication plan and failed to identify an alternate means of communication. During interview on 8/19/26 at 1:45 p.m., administrator verbalized alternate means of communication (Runners, going to sister facility) however failed documentation to support plan. No further documentation provided. The facility Emergency and Disaster Plans dated 3/2026, directed facility to develop guidelines, policies and procedures for emergency situations.			E0032	Continued from page 12 compliance and additional recommendations. 10/5/2026		10/05/2026
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner			F0628	Facility sent Ombudsman discharge notification report for R11 and R99. Residents that had been discharged from the facility between January 2026 to current have the potential to be affected by this deficient practice. Social Services Department sent Ombudsman discharge notifications retroactively from January to August for all previous discharged residents, which includes R11 and R99. All social services department staff have been educated on the Ombudsman Policy and Ombudsman notices.		10/05/2026

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F0628 SS = E	Continued from page 13 responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this			F0628	Continued from page 13 Social services director and/or designee to audit Ombudsman reports are being sent monthly for the next three months. Audit results will be reviewed through the QAPI process for compliance and additional recommendations. Date certain: 10/5/2026		10/05/2026

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F0628 SS = E	Continued from page 14 section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.			F0628			10/05/2026

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F0628 SS = E	Continued from page 15 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary			F0628			10/05/2026

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F0628 SS = E	Continued from page 16 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure notification was sent to the Office of the State Long-Term Care Ombudsman(OOLTC) for 1 of 2 residents (R99) reviewed for discharge and 1 of 2 residents reviewed for hospitalization (R11). Findings include: R99 R99's face sheet printed 8/18/26, indicated diagnosis of saddle pulmonary embolus (blood clot straddles the main fork of the heart affecting blood flow to the lungs). R99's censes sheet printed 8/18/26, indicated admit on 5/9/26 and billing stopped on 6/16/26. A facility report titled Admission/Discharge To/From Report dated 5/1/26 to 7/31/26, indicated R99 was discharged on 6/16/26. R99's electronic medical records (EMR) lacked evidence of OOLTC notification of discharge. R11 R11's quarterly MDS dated 7/21/26, indicated R11 was admitted to the facility on 1/27/26 and had			F0628			10/05/2026

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F0628 SS = E	Continued from page 17 moderately impaired cognition. The MDS indicated R11's most recent re-entry was on 7/16/26 from a short-term general hospital. R11's Census data dated 8/15/26, indicated R11 was in hospital status on 7/10/26 before a change back to active status on 7/16/26. R11's medical record was reviewed, and an indication that the ombudsman was notified of her transfer to the hospital was not found. An email from the Reginal Ombudsman (RO) received on 8/19/26, indicated facility discharge notifications had not been received for 6/2026 and 7/2026. During interview on 8/19/26 at 11:12 a.m., administrator stated Social Services Director (SSD) would be the person to upload and submit (currently on leave). SSD did upload reports for discharge, transfer and hospitalization but went to OOLTC in different district. This resulted in the facility's OOLTC not being notified of discharges, transfers, or hospitalizations from this facility for June and July. Administrator expected that the report titled Admission/Discharge To/From Report would be run and sent in the first 10 business days for the previous month. A Facility policy titled Ombudsman Hospital Transfer Report, updated 8/2025, directed staff to run a report in PointClickCare (electronic health record) monthly. The report would include transfers to hospital, discharge date and discharge/transfer to new facility. The report will be printed and faxed to the Ombudsman.			F0628			10/05/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike			F0584	R102, R16, and R58 had identified room repairs completed by the maintenance department. This included the identified paint, baseboard, and chipped windowsill repairs. Residents with rooms requiring paint, baseboards and chipped windowsills have the potential to be affected by this deficient practice. Facility completed a plant tour identifying rooms requiring repair and have put together a work plan for completion of identified areas. Residents who refuse a room repair will have their preference care planned.		10/05/2026

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F0584 SS = D	Continued from page 18 environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure maintenance services were provided in a timely manner to ensure a homelike living space was provided for 3 of 3 residents (R16, R58, R102) reviewed with room maintenance needs. Findings include: R58 R58's quarterly Minimum Data Set (MDS) dated 6/9/26, indicated R58 admitted to the facility on 9/18/25, had intact cognition, and no delusions or hallucinations during the look-back period (LBP).			F0584	Continued from page 18 All direct care staff will be educated on placing work orders via TELs for identified room repairs such as paint, chipped windowsills, and baseboards. The Administrator and/or designee will review TELs requests weekly to ensure that newly identified repairs for paint, windowsills, and baseboards are added to facility work plan with a target date listed x4 weeks, and then biweekly thereafter until work plan has been executed to completion. Audit results will be reviewed through the QAPI process for compliance and additional recommendations. 10/5/2026		10/05/2026

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F0584 SS = D	Continued from page 19 During an interview and observation on 8/16/26 at 1:56 p.m., R58 was observed sitting on her bed in her room. R58's room was observed with a space from the floor extending up to approximately six inches above the floor across all visible walls (did not have things covering the wall such as baseboard heating unit, closet, etc.) that appeared as if the room had previously had a baseboard and now did not. The remaining wall (the six-inch space extending from the floor) was in some areas: peeling back, blackish in color, or a tan color that was different from the wall that was above the six-inch space. R58 stated she believed that the wall had been like that since she had moved in last year, and she didn't like the way it looked. R102 R102's entry Minimum Data Set (MDS) dated 8/15/26, did not include a cognition assessment. During an interview on 8/16/26 at 1:56 p.m., R102 stated, "this place is a dump" and nothing gets fixed. R102 pointed at damage on their windowsill and their wall. R102 also expressed concern that there was ivy growing up the exterior wall outside their window. During an observation on 8/16/26 at 1:56 p.m., R102's windowsill was missing a triangular piece of wood in the center, approximately 5 inches long and 2 inches deep with a sharp edge, their wall was patched with plaster but not painted, approximately 2 feet by 2 feet, and brown vines were around the exterior of R102's window. R16 R16's quarterly MDS dated 6/18/26, identified R16 was cognitively intact. During an interview on 8/16/26 at 2:22 p.m., R16 stated there was a large hole in the plaster under the sink in their room and they had seen mice in the past. During an observation on 8/16/26 at 2:22 p.m., there was a hole surrounding the sink pipes in R16's room, approximately 1 foot by 1 foot, which appeared to be cut out. There were also unpainted plaster patches on the wall behind R16's bed, approximately 4 feet long.			F0584			10/05/2026

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F0584 SS = D	Continued from page 20 During an interview and observation on 8/18/26 at 2:42 p.m., the director of maintenance (DOM) stated he was the only maintenance staff member for the building, although occasionally the regional maintenance staff member would help out. The DOM stated he had started working at the facility approximately six months ago and stated that the building was “in terrible shape”. The DOM stated it was only him for the most part to complete all of the maintenance for the building, and he felt that he didn’t have enough time to complete all of the tasks that were assigned to him. Third floor: R58’s room was observed with a space from the floor extending up to approximately six inches above the floor across all visible walls (did not have things covering the wall such as baseboard heating unit, closet, etc.) that appeared as if the room had previously had a baseboard and now did not. The remaining wall (the six-inch space extending from the floor) was in some areas: peeling back, blackish in color, or a tan color that was different from the wall that was above the six-inch space. The DOM stated he was unaware of how long the wall had been like this. The DOM stated it was unlikely that the resident had removed the trim herself and felt it was most likely unfinished work from prior to when he started. Fourth floor: R16’s room was observed with a hole surrounding the sink pipes that was approximately one foot by one foot. There was also an unpainted white patched area on the wall behind R16’s bed that was approximately four feet long, with a varied height, with one foot at the tallest point. R102’s windowsill was observed to be missing a triangular piece of wood in the center that was approximately five inches long and two inches deep with a sharp edge. R102’s wall had an area that appeared to have been patched and left unpainted and was approximately two feet by two feet. Multiple brown vines were observed adhered to the exterior of R102’s window. The hole and unpainted patch in R16’s wall, the unpainted area, and damaged windowsill were reviewed with the DOM. The DOM stated that he thought the hole and unpainted areas had been that way for “a while” and it was on his list to fix, but he didn’t have enough time to finish everything. A policy regarding building maintenance was			F0584			10/05/2026

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F0584 SS = D	Continued from page 21 requested and received.			F0584			10/05/2026
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide ordered palm protectors and restorative interventions intended to maintain range of motion for 1 of 1 residents (R25) reviewed for restorative services and assistive devices. Findings include: R25's comprehensive Minimum Data Set (MDS), dated 6/9/26, identified the resident as cognitively intact, requiring maximum assistance with activities of daily living (ADLs), and having functional limitations in the range of motion of the upper and lower extremities. R25 was also dependent on staff for transfers, dressing, and personal hygiene. R25's care plan, dated 8/13/26, indicated that the resident required total assistance with ADLs, was non-ambulatory, required maximum assistance with bed mobility and transfers, and had severe contractures and spasms of the upper and lower extremities. The care plan further indicated that R25 received restorative therapy, including the use of palm protectors to prevent further contractures and muscle weakness.			F0688	R25's palm protector was applied per physician order. All residents with current orders for splints have the potential to be affected by this deficient practice. Facility reviewed all like residents and verified orders were up to date and completed visual observation that palm protectors and/or splints were applied per orders. All direct care staff were educated on residents with current orders for palm protectors and/or splints, and the importance of following physician orders as written, and documenting refusals as applicable. Director of Nursing and/or designee will audit 5 random residents with orders for splints/palm protectors weekly x4 weeks to verify that orders are carried out as written. Facility will then audit monthly x2 months following. Audit results will be reviewed through the QAPI process for compliance and additional recommendations. 10/5/2026		10/05/2026

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F0688 SS = D	Continued from page 22 R25 had a provider order for bilateral palm protectors to be worn at all times, with removal permitted for hand hygiene each shift and washing as needed. R25's treatment administration record (TAR), dated 8/17/26, indicated that the palm protectors had been applied. During an observation on 8/17/26 at 11:31 a.m., R25 was observed in the dining room seated in a wheelchair in a reclined position. A wedge was positioned between the resident's contracted legs. R25 did not have palm protectors in place on either hand. Both hands were contracted, and the wrists and elbows were curled toward the resident's body. During an observation on 8/18/26 from 7:30 a.m. to 8:22 a.m., R25 again did not have palm protectors in place. During an interview on 8/18/26 at 8:53 a.m., RN-C stated that the facility did not have a restorative rehabilitation department or restorative rehabilitation staff. RN-C stated that the physical and occupational therapy departments provided education and training related to ordered therapies. RN-C further stated that physician orders and the care plan were important and needed to be followed to ensure accurate care was provided to each resident. During an interview on 8/18/26 at 9:08 a.m., RN-D stated that residents were expected to receive restorative care and use assistive devices as ordered. RN-D stated that these interventions were important for maintaining alignment and decreasing contractures. During an interview on 8/18/26 at 9:36 a.m., LPN-A confirmed that R25 did not have the ordered palm protectors in place. LPN-A stated that R25 should have had the palm protectors due to the resident's contractures and that the palm protectors were intended to maintain strength and joint mobility. During an interview on 8/18/26 at 11:42 a.m., the Director of Rehabilitation (DOR) stated that therapists received orders to evaluate and treat residents and implemented a functional maintenance program based on their assessments and the residents' individual needs. DOR stated that the plan was placed in a folder, physical and occupational therapy staff completed the plan and trained facility staff, staff signed the training documentation, and each department head received a copy. DOR further stated that instructions were placed in the resident's room and hung on the wall. DOR confirmed that R25 had a			F0688			10/05/2026

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F0688 SS = D	Continued from page 23 written functional maintenance plan and hand protector education and that staff sign-off had been completed. During an interview on 8/18/26 at 2:44 p.m., the Director of Nursing (DON) stated that the expectation for the functional maintenance program and assistive devices was for staff to be properly trained on each resident's individual plan and to follow the care plan and physician orders to prevent contractures and maintain the resident's function and mobility. Document review and interviews further revealed that the facility did not have a policy addressing functional maintenance programs, assistive devices, or restorative rehabilitation services.		F0688			10/05/2026	
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure water was available and/or offered for 1 of 2 residents (R13) reviewed for hydration. Findings include: R13 R13's annual Minimum Data Set (MDS) dated 6/25/26, indicated R13 was		F0692	1. R13 offers water passes daily between 10-11 AM & 2-3 PM. 2. All residents in the facility that are not currently NPO or on a fluid restriction have the potential to be affected by this deficient practice. Water passes are to be completed 10-11 AM & 2-3 PM. 3. Nurse aides were educated on the importance of hydration and how to complete water passes daily. 4. Director of Nursing and/or designee will complete an observation of water passes being completed after all meals 3 time a week, and audited weekly for four weeks and then monthly for two months after. Audit results will be reviewed through the QAPI process for compliance and additional recommendations. 5. 10/5/2026		10/05/2026	

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F0692 SS = D	Continued from page 24 cognitively intact, dependent on staff for transfers to wheelchair and mobility in wheelchair. R13's diagnoses included chronic respiratory failure with hypoxia (low blood oxygen), diabetes, osteoarthritis of both knees, and mild protein/calorie malnutrition. R13's care plan dated 7/6/26 indicated R13 was at risk for malnutrition with a goal of being "free from signs and symptoms of dehydration." Interventions included to "provide food and beverages between meals." During interview and observation on 8/16/2026 at 11:29 a.m., R13 was lying in bed, hospital gown on that was not covering their shoulders or upper chest area, R13 stated they asked for water frequently and staff returned with it maybe 50% of the time. R13 stated this occurred on a daily basis. R13 stated they asked for water this morning, however no water was observed near resident. R13 stated they were frequently warm in their room and stated their fan was on most of the time. During observation on 8/17/2026 at 10:14 a.m., R13 observed lying in bed with bare shoulders and upper chest, box fan on floor blowing toward bed. A small plastic disposable cup noted on breakfast tray with approximately 60 milliliters (ml) clear liquid. R13 was observed to have dry lips as they applied lip moisturizer. During interview and observation on 8/17/2026 at 11:53 a.m., a plastic disposable cup with clear liquid was on R13's lunch tray, R13 stated it was the same water from her breakfast tray. R13 stated they used to have mugs staff would bring with ice water but have not been brought in a while; "days at least, probably weeks." Not noted to have larger container of water in room. During interview and observation on 8/18/2026 at 11:54 a.m., R13 stated they did get a mug of ice water last evening, however no mug was seen in the room. R13 stated they requested more water this morning, but they "probably forgot again". During observation on 8/18/2026 2:36 at p.m., R13 was observed lying in their bed sleeping with bare shoulders and upper chest, fan on, and no containers with water were noted in room. During interview and observation on 8/19/2026 at 9:15 a.m., no containers of water were noted in R13's room. R13 stated they asked for the water container to be replaced last evening. R13 was brought a small disposable cup of water with their medications, but no other fluids were provided. R17 R17's quarterly minimum data set (MDS) dated indicated R17 was cognitively intact. R17's diagnoses included quadriplegia (paralysis of the body below the neck), neurogenic bladder (bladder control problem), high blood pressure. During resident council interview on 8/18/2026 at 1:26 p.m., R17 stated their number one concern in facility was the staff do not pass water on shifts or ask residents if they want water. R17			F0692			10/05/2026

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F0695 SS = D	Continued from page 26 This REQUIREMENT is NOT MET as evidenced by: F695 Based on observation, interview and document review, the facility failed to ensure necessary emergency suction equipment was readily available and accessible at the bedside during a hypoxic event for 1 of 1 resident (R2) reviewed for respiratory care. R2's quarterly minimum data set (MDS) dated 6/24/26, severely cognitively impaired, diagnoses of acute and chronic respiratory failure with hypoxia (low blood oxygen), ventilator dependent (needs a machine to assist with breathing) and had a tracheostomy (surgical airway in the neck). R2 was dependent for all cares and required maximum assistance with activities of daily living (ADL's). R2's provider orders instructed to suction as needed every shift for excessive secretions/respiratory distress to maintain airway. Lavage (flush) with 3cc of normal saline with suctioning as needed for thick secretions. R2's orders instructed Volera (a system that expands lungs and airway and loosens secretions and dislodges mucus) for oscillation and nebulization treatment in-line (continuous) suction with trach for airway clearance three times a day. R2's care plan dated 8/1/26, indicated R2 required a ventilator due to acute and chronic respiratory failure. Interventions included staff to ensure suction equipment, bag-valve mask and artificial airway are functional and present at bedside. During observation on 8/17/26 at 10:11 a.m., R2 had copious amounts of thick, light yellow, sputum out of nose and mouth. R2 was on continuous oxygen (O2) saturation monitoring. The monitor started to alarm. At 10:13 a.m., R2's O2 saturations read 79% (normal was above 90%). Registered nurse (RN)-A entered the room and started gathering supplies. RN-A yelled down the hallway for someone to bring in sterile water and yelled for someone to call for the respiratory therapist (RT). O2 saturations dropped to 65%. At 10:16 a.m., RN-A yelled from bedside, requesting trach suction assistance, while using Ambu bag (bag to blow oxygen into the airway) to stabilize R2. Two unidentified staff entered room at 10:17 a.m. and found no sterile suction catheter in room. Unidentified staff left room to obtain in supply closet. RN-A asked for suction, while continuing to bag R2. At 10:18 a.m., O2 sats 83% while RN-A continued using the Ambu bag. At			F0695	Continued from page 26 supply room. Direct care staff including respiratory therapists and central supply coordinator were educated on the new inventory check process, and the expectation to maintain minimum par levels at 4 suction catheters, 4 sterile waters, and 4 yankers at bedside always. Director of Nursing and/or designee will audit 5 random residents with rooms for respiratory supplies weekly x4 weeks to verify that minimum par levels are followed. Facility will then audit monthly x2 months following. Audit results will be reviewed through the QAPI process for compliance and additional recommendations. 10/5/2026		10/05/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0695 SS = D	Continued from page 27 10:19 a.m., O2 sats 79%, sterile suction catheter was brought to R2’s room by staff member. RN-A suctioned R2 three times. At 10:23 am., R2’s O2 saturations were at 96% and R2 was placed back on ventilator. During an interview on 8/17/26 at 12:06 p.m., RN-A stated R2 had a recent increase in secretions recently. R2 had required increased suctioning for the past few days. RN-A verified there was no sterile water or suction available in R2’s room, so RN-A started bagging R2 to maintain O2 levels. RN-A stated respiratory therapy (RT) and nurses were responsible for stocking the emergency respiratory supplies at bedside. Nurses were expected to suction immediately when residents were having respiratory distress. During an interview on 8/17/26 at 12:33 p.m., RN-B stated she suctioned R2 approximately 3 times before 10:13 a.m., additionally, did a Volara treatment. When a nurse sees secretions, suction should be performed immediately. RT and RN manager were responsible for stocking emergency respiratory supplies in room. RN-B stated she used the last of the sterile suction and sterile water earlier in the day but did not restock the supplies. During an interview on 8/17/26 at 12:54 p.m., RT stated she rounds and stocks 2-3 times a week. There were no other audits or reviews on supplies performed. The emergency respiratory supplies should be at bedside. During an interview on 8/17/26 at 2:42 p.m., R2’s NP stated she was aware of the recently increased secretions and was attempting to manage it. The expectation was to have emergency respiratory supplies at bedside. NP further stated she would be concerned about the oxygenation of the organs and R2’s brain function with an episode of hypoxia that lasted six minutes. During an interview on 8/17/26 at 3:07 p.m., the director of nursing (DON) stated the expectation was to have emergency respiratory supplies at bedside. However, there wasn't a policy maintaining on trach suctioning or respiratory emergencies. A policy on Tracheal Suctioning, Respiratory Emergency Supplies and/or Suctioning Supplies policies were requested, however, the facility lacked these policies.			F0695			10/05/2026

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F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			F0791	R58 has been offered a health drive consent form for dental services, and added to in house facility routine visits going forward. All residents have the potential to be affected by this deficient practice. All residents and/or responsible parties were offered a health drive consent form for in-house dental services, and completed forms were given to the health unit coordinator to be added to facilities in house routine visits. All services that were declined will have the form uploaded to PCC. Admissions Coordinator and/or designee will be educated on the new process to provide residents with health drive consent forms on admission as part of the admit process. Health Unit Coordinator will be educated on uploading forms and coordination of services. Director of Nursing and/or designee will audit 1-3 random newly admitted residents to verify that the health drive consent form was offered and signed weekly x4 weeks. Facility will then audit monthly x2 months following. Audit results will be reviewed through the QAPI process for compliance and additional recommendations. 10/5/2026		10/05/2026

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F0791 SS = D	Continued from page 29 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental needs were evaluated and, if needed, acted upon or addressed timely to promote oral health for 1 of 1 residents (R58) reviewed for dental care. Findings include: R58’s quarterly Minimum Data Set (MDS) dated 6/9/26, indicated R58 admitted to the facility on 9/18/25, had intact cognition, and no delusions or hallucinations during the look-back period (LBP). The MDS indicated R58 had no broken or loosely fitting full/partial dentures and did not have mouth/facial pain, discomfort, or difficulty chewing. R58’s care conference note dated 12/19/25, included a section titled “Exams” that included a blank for “last dental exam” that was left empty and “comments” that indicated “no data”. R58’s care conference note dated 12/29/25, included a section titled “Exams” that included a blank for “last dental exam” that was left empty and “comments” that indicated “see doc tab”. R58’s care conference note dated 6/8/26, included a section titled “Exams” that included a blank for “last dental exam” and “comments” that were both left empty. R58’s Census data dated 8/15/26, indicated R58’s primary payment source was Medicaid. R58’s medical record was reviewed and did not indicate R58 had been offered, refused, or had received dental services while at the facility. During an interview and observation on 8/16/26 at 5:18 p.m., R58 was observed sitting on her bed with three front upper teeth that appeared shorter than the rest and slightly jagged. R58 stated that she used to have caps on her three now shorter front teeth but thought they had fallen off at least six months ago. R58 stated that she had not seen a dentist since she got here and didn’t recall anyone offering to help her make an appointment. R58 stated that it bothered her the way her teeth looked without the caps and wished someone would help her get them fixed. R58 stated she couldn’t recall if she had told anyone the caps had fallen off. During an interview on 8/18/26 at 1:45 p.m., licensed practical nurse (LPN)-A, the care			F0791			10/05/2026

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F0791 SS = D	Continued from page 30 coordinator for the unit, stated dental services should be offered to residents on admission. LPN-A stated that a document should be added related to offering this, but all he could find was related to vision services. LPN-A stated he would look further into the matter and get back to the surveyor. During an interview on 8/19/26 at 11:51 a.m. with the director of nursing (DON) and LPN-A, the DON stated that dental services were offered on admission or as requested. The DON confirmed she had reviewed R58's medical record and did not find a record that dental services were offered. The DON also stated that dental services should be discussed at care conferences. A policy regarding dental services was requested but not received.			F0791			10/05/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/16/26 to 8/19/26, 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: NO licensing orders were issued.			20000			09/08/2026

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 H52953757C (3124686) H52953758C (3104887) H52953759C (3083785) H52953764C (3066949) H52953767C (3066891) H52953760C (3050523) H52953761C (3042456) H52953765C (3032530) H52953763C (3025002) H52953766C (3020854) H52953768C (3010628) H52953769C (3002245) H52953770C (2995646) H52953771C (2985315) H52953772C (2747696) H52953776C (2737176) H52953773C (2642814) H52953774C (1111629, MN00105915) 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			20000			09/08/2026

Minnesota Department of Health

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20000	Continued from page 2 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			09/08/2026	
20890	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2 A Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide ordered palm protectors and restorative interventions intended to maintain range of motion for 1 of 1 residents (R25) reviewed for restorative services and assistive devices. Findings include:		20890	Facility acknowledged 9/8/2026		10/05/2026	

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20890	Continued from page 3 R25's comprehensive Minimum Data Set (MDS), dated 6/9/26, identified the resident as cognitively intact, requiring maximum assistance with activities of daily living (ADLs), and having functional limitations in the range of motion of the upper and lower extremities. R25 was also dependent on staff for transfers, dressing, and personal hygiene. R25's care plan, dated 8/13/26, indicated that the resident required total assistance with ADLs, was non-ambulatory, required maximum assistance with bed mobility and transfers, and had severe contractures and spasms of the upper and lower extremities. The care plan further indicated that R25 received restorative therapy, including the use of palm protectors to prevent further contractures and muscle weakness. R25 had a provider order for bilateral palm protectors to be worn at all times, with removal permitted for hand hygiene each shift and washing as needed. R25's treatment administration record (TAR), dated 8/17/26, indicated that the palm protectors had been applied. During an observation on 8/17/26 at 11:31 a.m., R25 was observed in the dining room seated in a wheelchair in a reclined position. A wedge was positioned between the resident's contracted legs. R25 did not have palm protectors in place on either hand. Both hands were contracted, and the wrists and elbows were curled toward the resident's body. During an observation on 8/18/26 from 7:30 a.m. to 8:22 a.m., R25 again did not have palm protectors in place. During an interview on 8/18/26 at 8:53 a.m., RN-C stated that the facility did not have a restorative rehabilitation department or restorative rehabilitation staff. RN-C stated that the physical and occupational therapy departments provided education and training related to ordered therapies. RN-C further stated that physician orders and the care plan were important and needed to be followed to ensure accurate care was provided to each resident. During an interview on 8/18/26 at 9:08 a.m., RN-D stated that residents were expected to receive restorative care and use assistive devices as ordered. RN-D stated that these interventions were important for maintaining alignment and decreasing contractures. During an interview on 8/18/26 at 9:36 a.m., LPN-A			20890			10/05/2026

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20890	Continued from page 4 confirmed that R25 did not have the ordered palm protectors in place. LPN-A stated that R25 should have had the palm protectors due to the resident's contractures and that the palm protectors were intended to maintain strength and joint mobility. During an interview on 8/18/26 at 11:42 a.m., the Director of Rehabilitation (DOR) stated that therapists received orders to evaluate and treat residents and implemented a functional maintenance program based on their assessments and the residents' individual needs. DOR stated that the plan was placed in a folder, physical and occupational therapy staff completed the plan and trained facility staff, staff signed the training documentation, and each department head received a copy. DOR further stated that instructions were placed in the resident's room and hung on the wall. DOR confirmed that R25 had a written functional maintenance plan and hand protector education and that staff sign-off had been completed. During an interview on 8/18/26 at 2:44 p.m., the Director of Nursing (DON) stated that the expectation for the functional maintenance program and assistive devices was for staff to be properly trained on each resident's individual plan and to follow the care plan and physician orders to prevent contractures and maintain the resident's function and mobility. Document review and interviews further revealed that the facility did not have a policy addressing functional maintenance programs, assistive devices, or restorative rehabilitation services. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could implement and revise policies and procedures related to the facility restorative program and include assistive device use. The DON, or designee, could provide training for all nursing staff related to the policies and procedures. The quality and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days			20890			10/05/2026
21325	Providing Routine & Emergency Oral Health Ser CFR(s): MN Rule 4658.0725 Subp. 1 Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each			21325	Facility acknowledged 9/2/2026		10/05/2026

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21325	Continued from page 5 resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental needs were evaluated and, if needed, acted upon or addressed timely to promote oral health for 1 of 1 residents (R58) reviewed for dental care. Findings include: R58’s quarterly Minimum Data Set (MDS) dated 6/9/26, indicated R58 admitted to the facility on 9/18/25, had intact cognition, and no delusions or hallucinations during the look-back period (LBP). The MDS indicated R58 had no broken or loosely fitting full/partial dentures and did not have mouth/facial pain, discomfort, or difficulty chewing. R58’s care conference note dated 12/19/25, included a section titled “Exams” that included a blank for “last dental exam” that was left empty and “comments” that indicated “no data”. R58’s care conference note dated 12/29/25, included a section titled “Exams” that included a blank for “last dental exam” that was left empty and “comments” that indicated “see doc tab”. R58’s care conference note dated 6/8/26, included a section titled “Exams” that included a blank for “last dental exam” and “comments” that were both left empty. R58’s Census data dated 8/15/26, indicated R58’s primary payment source was Medicaid. R58’s medical record was reviewed and did not indicate R58 had been offered, refused, or had received dental services while at the facility. During an interview and observation on 8/16/26 at 5:18 p.m., R58 was observed sitting on her bed with three front upper teeth that appeared shorter than the rest and slightly jagged. R58 stated that she used to have caps on her three now shorter front teeth but thought they had fallen off at least six months ago. R58 stated that she had not seen a			21325			10/05/2026

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21325	Continued from page 6 dentist since she got here and didn't recall anyone offering to help her make an appointment. R58 stated that it bothered her the way her teeth looked without the caps and wished someone would help her get them fixed. R58 stated she couldn't recall if she had told anyone the caps had fallen off. During an interview on 8/18/26 at 1:45 p.m., licensed practical nurse (LPN)-A, the care coordinator for the unit, stated dental services should be offered to residents on admission. LPN-A stated that a document should be added related to offering this, but all he could find was related to vision services. LPN-A stated he would look further into the matter and get back to the surveyor. During an interview on 8/19/26 at 11:51 a.m. with the director of nursing (DON) and LPN-A, the DON stated that dental services were offered on admission or as requested. The DON confirmed she had reviewed R58's medical record and did not find a record that dental services were offered. The DON also stated that dental services should be discussed at care conferences. A policy regarding dental services was requested but not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise the policies and procedures for the dental assessments and providing routine dental services, educate the appropriate personnel, and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (21) days.			21325			10/05/2026
21695	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 4 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure maintenance services were provided in a timely manner to ensure a homelike living space was provided for 3 of 3			21695	Facility acknowledged 9/8/2026		10/05/2026

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21695	Continued from page 7 residents (R16, R58, R102) reviewed with room maintenance needs. Findings include: R58 R58's quarterly Minimum Data Set (MDS) dated 6/9/26, indicated R58 admitted to the facility on 9/18/25, had intact cognition, and no delusions or hallucinations during the look-back period (LBP). During an interview and observation on 8/16/26 at 1:56 p.m., R58 was observed sitting on her bed in her room. R58's room was observed with a space from the floor extending up to approximately six inches above the floor across all visible walls (did not have things covering the wall such as baseboard heating unit, closet, etc.) that appeared as if the room had previously had a baseboard and now did not. The remaining wall (the six-inch space extending from the floor) was in some areas: peeling back, blackish in color, or a tan color that was different from the wall that was above the six-inch space. R58 stated she believed that the wall had been like that since she had moved in last year, and she didn't like the way it looked. R102 R102's entry Minimum Data Set (MDS) dated 8/15/26, did not include a cognition assessment. During an interview on 8/16/26 at 1:56 p.m., R102 stated, "this place is a dump" and nothing gets fixed. R102 pointed at damage on their windowsill and their wall. R102 also expressed concern that there was ivy growing up the exterior wall outside their window. During an observation on 8/16/26 at 1:56 p.m., R102's windowsill was missing a triangular piece of wood in the center, approximately 5 inches long and 2 inches deep with a sharp edge, their wall was patched with plaster but not painted, approximately 2 feet by 2 feet, and brown vines were around the exterior of R102's window. R16 R16's quarterly MDS dated 6/18/26, identified R16 was cognitively intact. During an interview on 8/16/26 at 2:22 p.m., R16			21695			10/05/2026

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21695	Continued from page 8 stated there was a large hole in the plaster under the sink in their room and they had seen mice in the past. During an observation on 8/16/26 at 2:22 p.m., there was a hole surrounding the sink pipes in R16's room, approximately 1 foot by 1 foot, which appeared to be cut out. There were also unpainted plaster patches on the wall behind R16's bed, approximately 4 feet long. During an interview and observation on 8/18/26 at 2:42 p.m., the director of maintenance (DOM) stated he was the only maintenance staff member for the building, although occasionally the regional maintenance staff member would help out. The DOM stated he had started working at the facility approximately six months ago and stated that the building was "in terrible shape". The DOM stated it was only him for the most part to complete all of the maintenance for the building, and he felt that he didn't have enough time to complete all of the tasks that were assigned to him. Third floor: R58's room was observed with a space from the floor extending up to approximately six inches above the floor across all visible walls (did not have things covering the wall such as baseboard heating unit, closet, etc.) that appeared as if the room had previously had a baseboard and now did not. The remaining wall (the six-inch space extending from the floor) was in some areas: peeling back, blackish in color, or a tan color that was different from the wall that was above the six-inch space. The DOM stated he was unaware of how long the wall had been like this. The DOM stated it was unlikely that the resident had removed the trim herself and felt it was most likely unfinished work from prior to when he started. Fourth floor: R16's room was observed with a hole surrounding the sink pipes that was approximately one foot by one foot. There was also an unpainted white patched area on the wall behind R16's bed that was approximately four feet long, with a varied height, with one foot at the tallest point. R102's windowsill was observed to be missing a triangular piece of wood in the center that was approximately five inches long and two inches deep with a sharp edge. R102's wall had an area that appeared to have been patched and left unpainted and was approximately two feet by two feet. Multiple brown vines were observed adhered to the exterior of R102's window. The hole and unpainted patch in R16's wall, the unpainted area, and damaged windowsill were reviewed with the DOM. The DOM			21695			10/05/2026

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21695	Continued from page 9 stated that he thought the hole and unpainted areas had been that way for “a while” and it was on his list to fix, but he didn’t have enough time to finish everything. A policy regarding building maintenance was requested and received. SUGGESTED METHOD OF CORRECTION: The administrator or designee should identify how it will maintain a homelike environment and ensure the facility have written policies and procedures developed and implemented. The facility should describe the procedures for maintaining and providing preventative maintenance in order to provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. The facility should educate staff who are responsible for reporting needed repairs and those in charge of maintenance and perform monthly routine environmental rounds. The facility should then perform measurable audits to ensure all are adhering to the policy. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21695			10/05/2026
21730	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 11 Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure repair recommendations from an outside pest control contractor were acted upon and completed timely to reduce the risk of rodent entry into the care center. In addition, the facility failed to follow Centers for Disease Control (CDC) recommended pest control procedures to ensure potential rodent entry points (i.e., holes in resident walls) were sealed, which had the potential to affect all 88 residents residing in the			21730	Facility acknowledged 9/8/2026		10/05/2026

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21730	Continued from page 10 facility. This caused actual harm to R30 when a potential rodent sighting caused psychosocial distress (i.e., crying, moaning, restlessness, agitation). Findings include: A CDC Controlling Wild Rodent Infestations article dated 4/8/24, indicated rodents were known to carry various diseases which could be spread to a human population. These diseases included salmonellosis, monkeypox, and tularemia. Further, the article indicated it was important to seal gaps or holes in exterior walls, adding, "mice can fit through a hole the width of a pencil (1/4 inch or 6 millimeters in diameter)." A CDC How to Seal Up to Prevent Rodents article dated 4/8/24, indicated that it was important to check inside your home for gaps or holes such as around windows, doors, “pipes leading to water heaters and furnaces”, behind appliances, around the pipes under sinks, around all water and sewer lines, etc. The article indicated that any holes you find should be sealed to prevent rodents from entering and recommended that small holes be filled with steel wool and then caulked/spray-foamed in place. The article also indicated that if a larger hole was found, a lath (steel) screen, cement, hardware cloth, or metal sheeting should be used to cover/fill it. R30 R30’s significant change MDS dated 7/27/26, indicated R30 had admitted to the facility on 6/1/26 and had severely impaired cognition. The MDS indicated R30 was dependent on staff for all activities of daily living (ADLs) and was receiving hospice care and tracheostomy care. The MDS did not include a complete resident mood interview. R30’s care plan dated 8/12/26, indicated R30 was diagnosed with respiratory failure, malnutrition, and a stroke. The care plan also indicated that R30 had quadriplegia (affects a person’s ability to deliberately control or move body parts from the neck down) and used a tracheostomy (a surgical hole in the front of the neck used to help with breathing) tube. The care plan's included diagnosis list did not reference anxiety. The care plan indicated R30 was completely dependent on a tube feeding for his nutrition and hydration support and was receiving no food by mouth. The care plan indicated that R30 was a “categorically a vulnerable adult” and staff were to monitor for signs of emotional			21730			10/05/2026

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21730	Continued from page 11 distress or mood/behavior changes. The care plan indicated R30 had an alteration in socialization due to “being unable to communicate”, although the resident was able to say some words and shake head to yes or no questions. The care plan indicated R30 was signed on to hospice cares on 7/20/26 with an end-stage disease process of a cerebral infarction (stroke). The care plan indicated that R30 had an alteration in cognition, so staff were to document changes in orientation, provide cues, reorientation/supervision as needed, and provide/maintain a consistent environment. R30’s medication and treatment administration record (MAR) dated 8/1/26 to 8/19/26 indicated the following: -on 7/21/26, 0.5 mg of lorazepam every four hours as needed. The as-needed lorazepam was given 14 times between 8/1/26 and 8/18/26. -on 8/11/20.5 mg of lorazepam every four hours was ordered for "terminal agitation". -target behavior monitoring was completed three times a day, with behaviors noted 10 of the 19 days. Behaviors included pulling lines for 7 of the days with interventions of reposition and redirection. The other 3 days anxiety was noted with interventions of repositioning and redirection. R30’s progress notes dated were reviewed. The note dated: -8/13/26 at 11:15 p.m., indicated that R30 had RR-A visit for the evening shift and R30 had been relaxed during the shift. -8/17/26 at 3:34 p.m., indicated R30 had no signs of pain, discomfort, or distress noted. -8/18/26 at 10:05 a.m., lorazepam was given for anxiety, “pulling”, and “hitting out”. -8/18/26 at 3:30 p.m., indicated that R30 was “pleasant, calm and cooperative with cares”. -8/18/26 at 6:07 p.m., the note indicated that resident representative (RR)-A had contacted the administrator related to a concern for a potential mouse. The note indicated that “tangible solutions” were discussed with RR-A. The note indicated that RR-A would like hourly checks to be completed through the evening and a room move tomorrow. The note indicated that a pest control company had been contacted to request a visit for tomorrow. The			21730			10/05/2026

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21730	Continued from page 12 note indicated that a grievance form was completed and the administrator apologized for the “inconvenience”. -8/19/26 at 12:20 a.m., written by registered nurse (RN)-G, indicated that R30 was “anxious and agitated” due to his “room condition.” The note indicated that R30’s “tracheostomy” was “accidentally” removed by R30, and a new tracheostomy set was placed. The note indicated that R30 was given his scheduled medications and then rested comfortably in bed. The note indicated that R30 was monitored every hour due to “emotional distress”. -8/19/26 at 7:26 a.m., indicated that the administrator had checked on R30 during morning rounds and R30 appeared to be sleeping comfortably in bed. The note indicated R30 had no anxiousness noted at the time of the visit. The note indicated that it was explained that a room move would be completed in the afternoon when R30 was up in his wheelchair, and R30 was agreeable to the plan. -8/19/26 at 10:30 a.m., indicated that RR-A had found the administrator and stated that “he” would now like to go to the hospital related to R30’s anxiety. An undated video shown by RR-A on 8/19/26 at 9:00 a.m., included a four-legged rodent that appeared to be anywhere from five to eight inches long (as a best estimate based on surrounding items) with a long tail. The rodent was observed walking down a hallway that at the end had a window, a baseboard heater, and a white foldable chair. In the video, the rodent was walking down the hallway towards the white chair, then along the bottom of the baseboard heater before the video ended. During an interview and observation on 8/19/26 at 9:00 a.m., RR-A was observed to take his phone out and show a video of a rodent in what appeared to be the fourth-floor hallway outside of R30’s room. RR-A stated that the rat seen in the video had exited R30’s room and entered the hallway last night. RR-A stated that he believed that a rat had been found in a trap in R30’s room a few nights ago. RR-A stated that R30 had limited mobility and didn’t keep any food in the room because R30 couldn’t eat anything by mouth. RR-A stated that about a week and a half ago he saw a mouse in R30’s room and he stepped on it and killed it. RR-A stated that last Thursday he had spent the night witnessed another mouse in the far-left corner of			21730			10/05/2026

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21730	Continued from page 13 the exterior wall of R30's room. RR-A stated that last night a mouse had been observed in R30's bed and that had caused a lot of anxiety for R30. RR-A claimed that the repeated rodent sightings over the last couple of weeks in the facility had caused R30 "emotional distress" and they even had to make changes to his anxiety medication. RR-A stated the facility offered to move R30 to a new room after the incident last night. RR-A stated he had contacted the hospice company to see if he could get additional resources to bring R30 home with him. R30 stated that the facility had now started to put interventions in place but felt that these interventions should have been done prior to the repeated rodent sightings. RR-A stated he was going to admit R30 to the hospital due to R30's emotional distress from the rodent presence in the building. During an observation on 8/19/26 at 9:05 a.m., R30's fourth-floor room was observed with the baseboard heating unit pipes coming through the far wall on the left-hand side of the exterior wall of the room. A hole greater than the size of a quarter was observed around the pipe's entrance into the room, and a large sticky trap by it appeared new (no dust, build-up, debris). R30 was sitting in the dining room and appeared restless/agitated as he was loudly moaning, grunting, and his brow appeared furrowed/grimaced. R30's signs of restlessness/agitation were observed to stop when RR-A walked over to him. RR-A was then seen telling R30 he was going to load the car and then he was coming back. R30, in response, made loud moaning noises and tense, grimacing facial expressions, as if upset. During an interview on 8/19/26 at 10:40 a.m., NP-A stated she had gotten a report of a rodent in the building today and sometime last month. NP-A stated that if she got a report of a rodent in a resident's room or bed, she wasn't exactly sure what she would do but would start by seeing if the resident had any changes in condition or any bites. NP-A stated that although it depended on the person, a person most likely wouldn't want a rodent in their bed or room, and it could be a "scary finding" depending on the individual. NP-A stated that if a resident has a tracheostomy tube with anxiety and agitation, there could be a potential concern for the tracheostomy tube being pulled out. NP-A stated that for R30, he did have a recent history of anxiety and restlessness, and they had been having to make medication changes for him. NP-A stated that although R30 had this anxiety history, pulling out his tracheostomy tube was a		21730			10/05/2026	

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21730	Continued from page 14 change for him, as she was unaware of him doing this in the past. NP-A stated that in the past and when she visited him, he generally seemed relatively comfortable, and she had only seen him “vocal” related to possible agitation once or twice. During an interview on 8/19/26 at 10:54 a.m., RN-B stated she was R30’s nurse for the day shift. RN-B stated R30 generally didn’t have signs of anxiety or agitation for her, and she can tell when he is moaning and groaning. RN-B stated R30 did not have a history of pulling at his tracheostomy, and given his anxiety related to the mouse in his room last night, they were completing hourly checks on him today. RN-B stated she did notice anxiety in him this morning, but his anxiety seemed to escalate as the day went on and the partner was in the building. During an interview and observation on 11:02 a.m. with pest control service technician (PCST)-A and the DOM, a hole that was approximately two inches by approximately six inches around the pipes leading to the baseboard heating unit in the left-hand corner of R30’s room was observed. PCST-A stated a rat could enter a resident room through a hole the size of a quarter and a mouse can get in through a hole the width of a pen. PCST-A stated that he believed this was where the rat had likely entered the resident’s room last night. PCST-A stated he would use a powder in the hole as a poison for the rats and, for now, would leave the hole open with the now unoccupied room door closed so the rat didn’t decide to enter a third-floor room instead or exit into the hallway. The DOM stated he had seen the video of a rat, and it appeared that the rat was in the fourth-floor hallway. PCST-A stated that the vines on the side of the building, even if they are treated and dead, could be used by the rats to climb and enter the building and suggested to the DOM that these be taken down. On 8/19/26 at 11:37 a.m., a call was made to the medical director with no answer and a message indicating his voicemail was full. A call was then placed at 11:38 to an office number provided by the facility, and a message was left asking for a call back. A call back was not received. During an interview on 8/19/26 at 12:01 p.m., nursing assistant (NA)-A stated she worked last evening with R30. NA-A stated that a family friend of R30 was in the room with R30 and had alerted her that they had seen a rodent in his room. NA-A stated she had then looked at R30, who was staring at the left-hand corner of the exterior wall of R30’s			21730			10/05/2026

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21730	Continued from page 15 room. NA-A stated she had then examined the area. NA-A stated the area had insulation on the floor that she hadn't noticed previously and it "looked like something had come out of the wall". NA-A then stated that she believed that a rodent had exited the wall from that corner of the room and entered R30's room. NA-A stated she had seen anxiety in R30 before this incident but saw "increased anxiety and agitation" after this incident and thought R30 now looked "fearful". NA-A stated that with R30's increased anxiety and agitation, R30 had pulled out his tracheostomy tube during the shift. NA-A stated she had elevated R30's bed high off the floor to try to help with his anxiety, and she checked on him often during her shift after the incident. During an interview on 8/19/26 at 12:24 p.m., RN-G stated that yesterday was her first day working with R30. RN-G stated that a family member of R30 had notified her that a rodent had been in R30's room and showed her a video of a rodent in the building. RN-G stated that when she entered R30's room, she had noticed insulation and what appeared to be pieces of wall on R30's floor that staff had to vacuum up. RN-G stated this had led her to believe that a rodent had entered R30's room. RN-G stated that after this incident, R30 became "emotionally distressed" and was "moaning and crying". RN-G stated that R30 became "agitated" and pulled his tracheostomy tube out, and she had to insert a new one. RN-G stated she gave him his scheduled anxiety medication, completed more frequent checks on him, and after the medication had time to take effect, R30 calmed down. Facility The facility's consulted pest control company service report dated 6/30/26, indicated the following actions were required of the facility: -A continued recommendation from 4/28/25, there was a hole behind the toilet in room 414 that should be addressed by maintenance. -A continued recommendation from 6/12/25, there were holes in the bathroom in room 413 that should be patched, as it could "lead to rodents entering the room". -A continued recommendation from 8/6/25, there were vines on the east side of the building that should be removed by staff, as rodents had been known to climb this in the past. The report included a picture of a brick building that appeared to be four stories with three windows, one above the other,			21730			10/05/2026

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21730	Continued from page 16 noted. The picture included various brown vines on the building that climbed up to approximately the bottom of the second window that was visible (third-story window). -A continued recommendation from 8/6/25, there was a hole in the exterior of the building by the dumpster area, above a window to the left of a staircase. The recommendation indicated this was a potential rodent entry point, and it should be repaired as necessary. The facility's consulted pest control company service report dated 7/29/26, indicated the following action required of the facility: -A continued recommendation from 6/12/25, there was a hole in the 413 bathroom that should be patched and was too big for the consultant company to patch. The facility's consulted pest control company service report dated 8/13/26, indicated the following action required of the facility: -There were "rodent concerns in room" 415 and a "big hole" in the bathroom that needed to be filled with drywall. -There were "rodent concerns in room" 416 and a "big hole" under the sink that needed to be filled with drywall. -A continued recommendation from 8/4/26, there were "major" gaps around plumbing, with the recommendation to fill in the gap behind the toilet. The facility's consulted pest control company service report dated 8/17/26, indicated the following action required of the facility: -A continued recommendation from 8/4/26, there were "major" gaps around plumbing, with the recommendation to fill in the gap behind the toilet. R7's quarterly Minimum Data Set (MDS) dated 7/16/26, indicated R7 admitted to the facility on 4/17/26, had intact cognition, and no delusions or hallucinations during the look back period (LBP). During an interview and observation on 8/19/26 at 8:42 a.m., R7 sat on the edge of his bed with oxygen tubing attached to himself (over the ears and inserted into the nose) with extra tubing lying on the floor. R7's bathroom was observed with a hole that was greater than the size of a quarter around each			21730			10/05/2026

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21730	Continued from page 17 side of the pipes and was visible behind the toilet where the pipes entered the wall. R7 stated that he saw a mouse coming through the hole a week ago. R7 stated that the mouse got stuck in his oxygen tubing on his floor and he had to help it get out. R7 stated he saw mice every day in the facility but not always coming out of the hole in his bathroom. R16’s quarterly MDS dated 6/18/26, indicated R16 admitted to the facility on 3/17/26, had intact cognition, and no delusions or hallucinations during the LBP. During an interview on 8/16/26 at 2:22 p.m., R16 stated there was a large hole in the plaster under the sink in their room, and they had seen mice in their room in the past. R16 stated that something had bitten him in bed last night and showed two pinpoint scabs approximately two centimeters apart on his lower calf. R58’s quarterly MDS dated 6/9/26, indicated R58 admitted to the facility on 9/18/25, had intact cognition, and no delusions or hallucinations during the LBP. During an interview on 8/16/26 at 5:15 p.m., R58 stated that the facility had an “issue” with mice as she saw mice run across the floor in her room last month. R102’s entry tracking MDS dated 8/15/26, indicated R102 admitted to the facility on 8/15/25. An admission/comprehensive MDS with cognition data was not yet completed. During an interview on 8/16/26 at 1:56 p.m., R102 stated the facility was not well cared for, and nothing got fixed. R102 also expressed concern that there was ivy growing up the exterior wall outside their window. Multiple brown colored vines were observed covering R102’s fourth-floor window. During an interview and observation on 8/18/26 at 2:42 p.m., the director of maintenance (DOM) stated he was the only maintenance personnel for the building, although occasionally the regional maintenance staff member would help. The DOM stated he had started working at the facility approximately six months ago and stated that the building was “in terrible shape”. The DOM stated it was only him for the most part to complete all the maintenance for the building, and he felt that he didn’t have enough time to complete all the tasks that were assigned to him. R16’s room was observed with a hole surrounding the sink pipes that			21730			10/05/2026

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21730	Continued from page 18 was approximately one foot by one foot. Multiple brown vines were observed adhered to the exterior of R102's window. The DOM stated that he thought the hole had been that way for “a while” and it was on his list to fix, but he didn’t have enough time to finish everything. During an observation and interview on 8/19/26 at 9:14 a.m. with the DOM, -brown vines were observed as described in the 6/30/26 consultant pest control report but seemed to have expanded a couple of feet and now covered a resident window. The DOM stated he had treated the vines but thought that since they were thought to be dead, the rats would be unable to climb the vines, and it would also be a lot of work to take them down. -A hole in the exterior of the building by the dumpster area was observed, above a window to the left of a staircase, and was approximately 1.5 inches in diameter. The maintenance director stated he had been unaware of this hole, but it looked like the area needed to be filled. -An approximately inch gap around the outside of the 413-bathroom (shared with 411) toilet pipes was observed. -In 414 (shared with 412) bathroom, a hole that was at least three inches by one inch was observed behind the toilet where the pipes enter the wall. -In 415's (shared with 417) bathroom, a hole that was greater than the size of a quarter around each side of the pipes was visible behind the toilet where the pipes entered the wall. The DOM stated that he did believe that rats or mice would be able to enter the holes observed in the 413, 414, and 415 bathrooms. The DOM stated he believed that these holes had been present since at least when he started six months ago. The DOM stated that the facility had made fixes in the main kitchen as they had previously had issues with rodents entering this area. The DOM stated that, as it was mainly only him working on these fixes, he was unable to get to fixing the holes in the resident rooms due to time constraints. During an interview on 8/19/26 at 2:23 p.m., the administrator stated the building previously didn’t have a “great” maintenance structure. The administrator stated that since the current DOM took over, he had been patching holes, they completed maintenance on the kitchen, were completing			21730			10/05/2026

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21730	Continued from page 19 monthly building plant tours, and redid a walkway. The administrator stated the facility had “a lot” of things that still needed to be done, but the facility had made “a lot” of improvements since the DOM started. The administrator stated the DOM had been the sole person completing the maintenance on the building with occasional help from the regional maintenance staff member. The DOM stated the facility depended on corporate approval for getting additional resources such as staff for completing maintenance projects. The administrator stated she had been made aware of a potential rodent from RR-A and had ensured more frequent monitoring was completed on R30. The administrator stated she had gone up today to check on R30 and felt that R30 was not showing any anxiety or agitation at that time. The administrator stated she had offered a room change to RR-A. The administrator stated that at first RR-A was agreeable to this, but then RR-A’s anxiety was “out of control” and R30 ended up transferring to the hospital. The administrator stated she felt like RR-A’s anxiety led to an increase in R30’s anxiety. The administrator stated that she felt that R30’s anxiety was caused by multiple factors and did not feel it could be attributed to the rodents in the building. A Policy regarding pest control was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of maintaining an effective pest control program. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure pests is controlled to ensure a clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21730			10/05/2026
21925	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 29 Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with			21925	Facility acknowledged 9/8/2026		10/05/2026

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21925	Continued from page 20 the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure notification was sent to the Office of the State Long-Term Care Ombudsman(OOLTC) for 1 of 2 residents (R99) reviewed for discharge and 1 of 2 residents reviewed for hospitalization (R11). Findings include: R99 R99's face sheet printed 8/18/26, indicated diagnosis of saddle pulmonary embolus (blood clot straddles the main fork of the heart affecting blood flow to the lungs). R99's censes sheet printed 8/18/26, indicated admit on 5/9/26 and billing stopped on 6/16/26. A facility report titled Admission/Discharge To/From Report dated 5/1/26 to 7/31/26, indicated R99 was discharged on 6/16/26. R99's electronic medical records (EMR) lacked evidence of OOLTC notification of discharge. R11 R11's quarterly MDS dated 7/21/26, indicated R11 was admitted to the facility on 1/27/26 and had moderately impaired cognition. The MDS indicated R11's most recent re-entry was on 7/16/26 from a short-term general hospital. R11's Census data dated 8/15/26, indicated R11 was in hospital status on 7/10/26 before a change back			21925			10/05/2026

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21925	Continued from page 21 to active status on 7/16/26. R11's medical record was reviewed, and an indication that the ombudsman was notified of her transfer to the hospital was not found. An email from the Reginal Ombudsman (RO) received on 8/19/26, indicated facility discharge notifications had not been received for 6/2026 and 7/2026. During interview on 8/19/26 at 11:12 a.m., administrator stated Social Services Director (SSD) would be the person to upload and submit (currently on leave). SSD did upload reports for discharge, transfer and hospitalization but went to OOLTC in different district. This resulted in the facility's OOLTC not being notified of discharges, transfers, or hospitalizations from this facility for June and July. Administrator expected that the report titled Admission/Discharge To/From Report would be run and sent in the first 10 business days for the previous month. A Facility policy titled Ombudsman Hospital Transfer Report, updated 8/2025, directed staff to run a report in PointClickCare (electronic health record) monthly. The report would include transfers to hospital, discharge date and discharge/transfer to new facility. The report will be printed and faxed to the Ombudsman. SUGGESTED METHOD OF CORRECTION: The Director of Social Work or designee could develop, review, and/or revise policies and procedures to ensure the ombudsman received notification of all hospitalizations. The Director of Social Services or designee could educate all appropriate staff on the policies and procedures. The Director of Social Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days			21925			10/05/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 17, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Emerald at St. Paul, 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			09/08/2026

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

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The Emeralds of St. Paul is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1982, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 100 beds and had a census of 89 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			09/08/2026

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K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 8/17/2026, at 10:45 AM, it was revealed by a review of available documentation, the facility did not have documentation on the annual fuel testing. An interview with the Maintenance Director verified			K0918	Maintenance Director has completed fuel testing requirement. Life safety book was reviewed to verify that all required testing for facility electrical systems was up to date. The Maintenance Director was educated on ensuring facility testing requirements follow Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.8. The Maintenance Director will audit the life safety book weekly x4 weeks to ensure that all testing records remain up to date. 10/5/2026		10/05/2026

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K0918 SS = F Bldg. 01	Continued from page 3 this deficient finding at the time of discovery.			K0918			10/05/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to seal the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1). This deficient finding could have a moderate impact on the residents within the facility. Findings Include: On 8/17/2026, at 11:55 AM, observations and staff interview revealed that there were ceiling tiles missing in the Rehab space on the 1st floor and in the Housekeeping Office/Storage Room in the Basement. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0372	Maintenance Director repaired ceiling tiles in the rehab space and housekeeping office/storage room. All offices and storage spaces were audited to identify if there are other areas of ceiling tile gaps. All repairs were completed as identified. The Maintenance Director was educated on Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1), and that all ceilings should maintain ceiling tiles in place. The Maintenance Director and/or designee will audit offices and storage spaces weekly x4 weeks to ensure that all rooms remain in compliance. 10/5/2026		10/05/2026
K0293 SS = D Bldg. 01	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination			K0293	Exit signs located in the kitchen and the 3rd floor C Wing have been repaired by the Maintenance Director and are in working condition. All exit signs have been audited to identify if similar repairs are needed. The Maintenance Director has been educated on life		10/05/2026

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K0293 SS = D Bldg. 01	Continued from page 4 also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the egress requirements in accordance with NFPA 101, 7.10.1.5.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 8/17/2026, at 11.25 AM, observations and staff interview revealed that there were 2 exit signs that were inoperable. 1 was in the Kitchen and the other at the exit on the C Wing on the 3rd floor. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0293	Continued from page 4 safety code pertaining to egress requirements. The Maintenance Director and/or designee will audit all exit sign doors weekly x4 weeks to ensure that signs remain illuminated and in good working condition 10/5/2026		10/05/2026
K0311 SS = D Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to seal the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1). This deficient finding could have an isolated impact on the residents within the facility.			K0311	3rd floor housekeeping closet was repaired so that there is no floor penetration. All housekeeping closets were audited to identify if similar repairs are needed. The Maintenance Director was educated on ensuring that all vertical openings between floors are enclosed per life safety code guidelines. The Maintenance Director and/or designee will audit all housekeeping closets weekly x4 weeks to ensure that closets remain properly enclosed. 10/5/2026		10/05/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0311 SS = D Bldg. 01	Continued from page 5 Findings Include: On 8/17/2026, at 11:20 AM, observations and staff interview revealed that there was a penetration through the floor in the 3rd Floor Housekeeping Closet. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0311			10/05/2026
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are			K0923	Oxygen tank was removed from room 318 and stored in the 1st floor oxygen room. Oxygen tank being stored in 4th floor supply closet has been removed and stored in 1st floor oxygen room. All residents with an O2 order were audited to verify all tanks are being stored in room if being actively utilized. All supply rooms were audited to verify no oxygen is being stored inappropriately. All direct care staff and maintenance director were educated on the protocol for proper storage of oxygen tanks. The Maintenance Director and/or designee will audit 3 random resident rooms with current orders for O2 weekly x4 weeks to ensure storage requirements are being met. They will also audit 3 supply rooms weekly x4 weeks to ensure that O2 is not stored in these areas. 10/5/2026		10/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245295		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/17/2026	
NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT ST PAUL LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE , SAINT PAUL, Minnesota, 55102			
(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
K0923 SS = D Bldg. 01	Continued from page 6 protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to construct a storage space that is of non-combustible materials in accordance with NFPA 99, 11.3.4.2 and 11.7.4, 2012 Edition. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 8/17/2026, at 11:20 AM, observations and staff interview revealed the following: 1. There were oxygen tanks being stored within the 4th floor supply room without proper signage. 2. There was an oxygen concentrator observed within room 318 that was not connected to anything and there was no resident within the room. This is considered in storage. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0923			10/05/2026