



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 21, 2025

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: February 14, 2025

Dear Administrator:

On March 14, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 21, 2025

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

Re: Reinspection Results
Event ID: 2CRT12

Dear Administrator:

On March 14, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 3, 2025

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: December 6, 2024

Dear Administrator:

On January 06, 2025, we informed you of imposed enforcement remedies.

On February 14, 2025, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 6, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 6, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 6, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 6, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Specialty Care Community will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 6, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Renee McClellan, 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: renee.mcclellan@state.mn.us

Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 6, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A

written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

Good Samaritan Society - Specialty Care Community

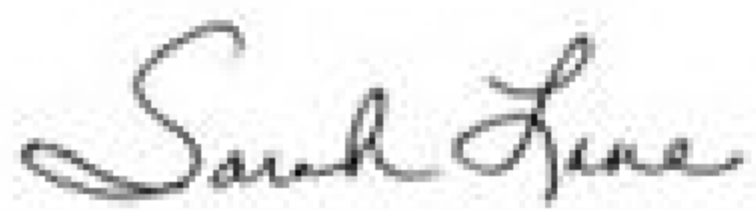
March 3, 2025

Page 5

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 3, 2025

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 2CRT11

Dear Administrator:

The above facility was surveyed on February 10, 2025 through February 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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.

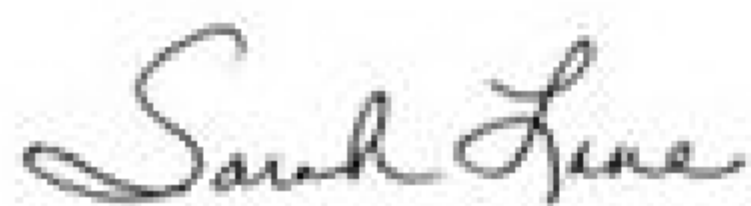
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Renee McClellan, 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: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces the letter dated March 3, 2025 indicating the results of the new survey cycle.

Electronically delivered
March 11, 2025

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: February 14, 2025

Dear Administrator:

On February 14, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 May 14, 2025 (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 August 14, 2025 (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:

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,



Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File



Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces the letter dated March 3, 2025.

Electronically delivered
March 11, 2025

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 2CRT11

Dear Administrator:

The above facility was surveyed on February 10, 2025 through February 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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

March 11, 2025

Page 2

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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

Sincerely,



Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BLDG B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 02/12/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society-Speciality Care Community was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/13/2025

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 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BLDG B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422		
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Good Samaritan Society - Specialty Care Community is a 3-story building with a basement that was built in 2012 and determined to be Type II (111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with complete smoke detection that is monitored for automatic fire department notification.	K 000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BLDG B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422		
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K 321	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 02/12/2025 between 9:00AM and 12:00 PM, it was revealed by observation the door to the soiled utility room on the third floor in the Boundary Waters wing did not latch when testing the self-closing device. 2. On 02/12/2025 between 9:00AM and 12:00 PM, it was revealed by observation the door to the soiled utility room on the first floor in the Bluff County wing did not latch when testing the self-closing device. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 321	1.The doors to the soiled utility rooms on the Boundary Water and Bluff Country units was repaired on 3/13/25. 2.The administrator was educated on NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1,and 7.2.1.8.1. 3.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations. 4.The administrator and/or designee is responsible for the corrective actions and monitoring of compliance. 5.Compliance Date 3/14/2025.		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324			3/14/25

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K 324	Continued From page 4 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/12/2025 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility provided a kitchen hood suppression system inspection dated 04/17/2024 but could not provide documentation of an inspection within six			K 324	1.The suppression hood inspection and testing report was completed on 3/10/25. There were no reported deficiencies. 2.The administrator was educated on NFPA 101 (2012 edition),Life Safety Code, section 19.3.2.5.1 and 9.2.3,and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. 3.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations.		

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K 372	Continued From page 6	K 372			
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.4, 6.5.11, 6.5.12, 6.6.3, and 6.6.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/12/2025 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that the damper inspection report dated 01/29/2024 showed that there were 4 dampers that failed inspection due to inadequate	K 521	4.The administrator and/or designee is responsible for the corrective actions and monitoring of compliance. 5.Compliance Date 3/14/2025. 1.The vendor for the Fire/Smoke Damper audit was called on 3/13/25 for clarification on the affected areas. Upon confirmation, these areas will be repaired. 2.The administrator was educated on NFPA 101 (2012 edition),Life Safety Code, section NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105(2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.4, 6.5.11, 6.5.12, 6.6.3, and6.6.4 3.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3. Results will be brought to the		3/14/25

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K 521	Continued From page 7 access, and the Maintenance Director stated that the testing has not been completed on the four dampers that were not accessible. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	QAPI committee for further recommendations.	3/14/25	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/12/2025 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing	K 712	4.The administrator and/or designee is responsible for the corrective actions and monitoring of compliance. 5.Compliance Date 3/14/2025. 1.The fire drill schedule was reviewed on 2/12/25. 2.The administrator was educated on NFPA 101 (2012 edition),Life Safety Code, section NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. 3.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations.		

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K 712	Continued From page 8 that a fire drill had been completed during the third shift during the third and fourth quarter of 2024. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 712	4.The administrator and/or designee is responsible for the corrective actions and monitoring of compliance. 5.Compliance Date 3/14/2025.		

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E 000	Initial Comments	E 000			
	On 2/10/25-2/14/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance.				
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 2/10/25-2/14/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.				
	The following complaints were reviewed: H52796841C (MN00110396) H52797041C (MN00106775) H52797042C (MN00106882) H52797043C (MN00103564) H52797044C (MN00102143) H52797623C (MN00110719) (MN00110734) 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				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/2025

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 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.

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F 000	Continued From page 1	F 000			
F 554 SS=D	validate substantial compliance with the regulations has been attained. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medication assessment (SAM) was completed to allow residents to safely administer their own medications for 1 of 1 (R140) resident observed with medications at bedside. Findings include: R140's admission Minimum Data Set (MDS) dated 2/10/25, indicated intact cognition and diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). If further indicated R140 required partial assistance with most activities of daily living (ADL). R140's physician's orders dated 2/5/25, indicated Breo Ellipta Inhalation Aerosol Powder Breath Activated 200-25 microgram (MCG)/ACT (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day for chronic obstructive pulmonary disease (COPD). Rinse mouth after each use. Notify the nurse manager if R140 refuses or unable to rinse. It further included an order dated 2/5/25, indicating	F 554			3/6/25
			Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F554 (S/S D): Resident Self Admin Meds 1.The inhalers found in the affected residents (R140) were removed immediately. The affected resident (R140) discharged from the facility of 2/24/25. 2.All residents receiving inhaler treatment have the potential to be affected by this deficient practice. These residents were reviewed by 3/6/25 to ensure that a self-administration of medications (SAMS)		

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F 554	Continued From page 2 Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for shortness of breath (SOB). R140's physician's orders lacked an order to self administer medication. R140's medical record lacked an assessment to self administer medications. R140's care plan lacked documentation R140 was able to self administer his medications. During observation on 2/10/25 at 2:15 p.m., R140 was sitting in his room in his wheelchair. On the nightstand were 3 inhalers, two of which were Breo Ellipta inhalers and one was an albuterol inhaler. During observation and interview on 2/10/25, at 2:18 p.m. registered nurse (RN)-C verified R140 had medications (3 inhalers) at bedside. RN-C also verified R140 was not able to administer his own medications and they should not be kept at bedside or in his room unless he had been assessed for safety and there was a doctor's order, which he didn't have. RN-C explained to R140 that it was important to not keep medications in his room without a lock box in case a resident wandered into his room and decided to take it. During interview on 2/14/25 at 10:15 a.m., the director of nursing (DON) stated in order for a resident to be able to administer their own medications they would need to be assessed to determine if it was safe to do so, and then they would need to obtain a physician's order. The DON further indicated medications should not be	F 554	assessment was completed if needed. The orders for inhalers for residents not deemed appropriate for self-administration of medications were updated to reflect, Inhaler not to be left at bedside. 3.To ensure systemic changes are sustained, all staff will be provided with education on providing medication as ordered by the physician with a focus on ensuring medications are not left at bedside via an in-person meeting by 3/6/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

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F 554	Continued From page 3 kept at bedside even if the resident has been deemed safe to self administer their medications. They need to be kept in a lock box in the resident's room in order to prevent another resident from possibly wandering in there and taking the wrong medications. Also if resident's are self administering their medications without being assessed, they may take the wrong dose or at the wrong time, etc. The facility's policy regarding the self administration of medications dated 10/29/24, indicated the procedure for determining if a resident could self administer their medications was as follows: 1. Complete the Resident Self-Administration of Medications UDA to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process. The interdisciplinary team must determine whether each resident who expresses a desire to self-administer medications can do this safely. It is also recommended that the initial MDS be completed prior to this review. Areas of the MDS that may impact the team ' s decision include B, C, D, E and J. A query could be used by the team to review MDS coding on these and other areas. 2. The interdisciplinary team will determine if the resident has any specific educational needs or if he or she requires any accommodation to selfadminister medication(s). When responding to question 3 - numbers 2 through 6 will create a progress note for Teaching - Resident/Family. 3. The interdisciplinary team will also determine where medications will be stored. This can be at the nurses ' station, in a locked medication cart, a locked compartment or locked drawer in the resident ' s room. If the medication is stored at	F 554			

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F 554	Continued From page 4 the resident ' s bedside, an additional key must be kept by nursing employees. 4. The interdisciplinary team will determine the location where the medication will be self-administered. Medication cannot be left within reach of another resident and must be under the control of the resident who is self administering. 5. The interdisciplinary team will determine who will document the medication administration (e.g., the resident or the nursing employees). If the resident will be documenting his or her medication, it is recommended that the Resident Self-Administration Record (GSS #261) be used and scanned into 6. The interdisciplinary team ' s determination that the resident can safely selfadminister medications must be documented in the Resident Self- Administration of Medication UDA. 7. A physician ' s order must be obtained prior to the resident self-administering medications. a. The order must be specific to the medications being self-administered (e.g., "Bengay ointment tid prn for leg discomfort. May be kept at bedside for self-administration" or, "May have all oral medications at bedside for self-administration"). Update with new orders as needed. 8. The care plan must indicate which medications the resident is selfadministering, where they are kept, who will document the medication and the location of administration, if applicable. Document quarterly on PN - Care Plan Review. 9. The resident ' s ability to continue to safely self-administer medication must be reviewed during the care planning process. It is recommended that this be done at least quarterly and with any significant change. If the resident is no longer able to self-administer medications	F 554			

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F 554	Continued From page 5 safely, the physician must be notified, and medication will then be administered by nursing employees. 10. All medications that the resident stores in his or her room must be reconciled (counted or observed for amount used, e.g., ointments and inhalers) and documented by a licensed nurse at least weekly on the MAR. 11. Medication errors made by the resident during self-administration are not to be counted in the location ' s medication error rate. 12. Some states have specific rules regarding self-administration of medications. Please check your state regulations for additional information. Periodic verification with the individual state regulations is encouraged due to potential changes.	F 554			
F 584 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 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.	F 584			3/6/25

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F 584	Continued From page 6 §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: During observation, interview, and document review the facility failed to clean and maintain residents wheelchairs for 2 of 2 residents (R3, R33). Findings include: R3 R3's quarterly Minimum Data Set (MDS) dated 12/26/24, indicated moderately impaired cognition, and diagnoses of Huntington's disease (HD), dementia, dependence on a wheelchair, and was dependent on staff for most activities of daily living (ADL) and mobility.	F 584	F584 (S/S D): Safe/Clean/Homelike Environment 1.The assistive devices for the affected residents (R3 and R33) were deep cleaned on 2/13/25. The affected residents (R3 and R33) were determined to need more frequent cleaning than previously scheduled, as a result the assistive device cleaning schedule for this unit was reflected to update a daily cleaning for the affected residents (R3 and R33). 2.All residents with assistive devices have the potential to be affected by this deficient practice. These residents were reviewed by 3/6/25 to ensure that the		

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F 584	Continued From page 7 R3's care plan dated 1/16/25, indicated R33 had limited physical mobility and was at risk for falls related to HD as evidenced by needing assistance for mobility. Frequently refused to wear shoes, slippers or diabatic shoes. Had a history of putting himself on the floor and scooting. Also had a history of alleging falls and getting himself up from. Assist to propel Broda Chair as needed. It further included an intervention of mobility: Broda Chair with pressure redistribution cushion and self releasing front latching seat beat. Uses Broda chair for ambulation. R33 R33's quarterly Minimum Data Set (MDS) dated 1/16/25 indicated, moderately impaired cognition and diagnoses of Huntington's disease, dementia, uses a wheelchair, and requires substantial assistance with mobility. R33's care plan dated 2/7/25, indicated limited physical mobility related to Huntington's disease (HD), chorea as evidenced by using a wheelchair. It further indicated an intervention of mobility: R33 was able to propel self in Broda wheelchair for short distances, required total assist of 1 to propel for long distances. During observation on 2/12/25 at 8:19 a.m., R33 was sitting at the table in the dining room in her Broda chair. There was copius amounts of dried on and built up food on both of the wheelchair wheels, specifically in between the spokes. During observation on 2/12/25, at 8:25 a.m., R3 was sitting in the dining room in his wheelchair. There was copious amounts of dried food spilled	F 584	assistive device cleaning schedule and frequency of cleaning for these residents was appropriate. 3.To ensure systemic changes are sustained, all staff will be provided with education on cleaning assistive devices and how to request additional cleaning for assistive devices outside of the scheduled cleaning via an in-person meeting by 3/6/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

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F 584	Continued From page 8 on both wheels, and several large clumps of a dried white substance on the right wheel. During observation and interview on 2/12/25 at 9:41 p.m., registered nurse (RN)-E was shown the copious amounts of food on R3's wheelchair, stating "I'll care of it." RN-E further stated the nursing assistants (NA) on the overnight shift were responsible for cleaning the resident's wheelchairs and there was a schedule of which resident's wheelchair was supposed to be cleaned each day. The surveyor also asked about R33's wheelchair and she stated "I just cleaned hers last night!" The surveyor and RN-E went into R33's room to look at her wheelchair and RN-E verified there was still dried, built up food on the right wheel in between the spokes. During interview on 2/14/25 at 10:15 a.m. the director of nursing (DON) stated the nursing staff who worked on the overnight shift were responsible for cleaning the resident's wheelchairs and there was a schedule to determine which resident's wheelchairs should be cleaned on which night. The wheelchairs were typically cleaned once a week and if they need it washed more often, maintenance should take care of it. The Woodlands assistive device washing schedule last updated on 1/5/25, indicated R3's wheelchair was supposed to be cleaned on Thursday every other week (week 1) and R33's wheelchair was also supposed to be cleaned on Thursday's every other week (week 2). It further indicated 226 and 227 (room numbers) are to be washed every night which was hand written on the schedule.			F 584			

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F 584	Continued From page 9	F 584			
F 585 SS=E	A facility policy regarding cleaning the resident's wheelchairs was requested but the Administrator stated they do not have a specific policy for wheelchair cleaning. Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585			3/6/25

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F 585	Continued From page 10 (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a			F 585			

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F 585	Continued From page 11 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents knew how to file a grievance and that grievance forms were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 4 of 4 residents (R29, R32, R37 and R39) reviewed for grievances. This had the potential to affect all residents residing in the facility. Findings include: On 2/12/25 at 11:00 a.m., a resident council meeting was held with four residents which included R29, R32, R37 and R39. During the resident council meeting, all four residents	F 585	F585 (S/S E): Grievances 1.The affected residents (R29, R32, R37 and R39) received re-education on how to file grievances on 3/5/25. 2.All residents have the potential to be affected by this deficient practice. Acrylic brochure holders were purchased on 2/22/25 and installed on 2/26/25 to easily hold blank grievance forms to allow easy access to residents, visitors, and staff. Information on how to file grievances has been added to the monthly resident council meeting agenda. 3.To ensure systemic changes are sustained, all staff will be provided with education on how to assist residents with completing grievances as well as were		

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F 585	Continued From page 12 indicated they were not aware of how to file a grievance or where to find a grievance form. All four residents stated that they knew they could talk to the previous social worker, but since he left none of them felt they could discuss grievances with social services director (SSD). During interview on 2/13/25 at 9:45 a.m., SSD stated the grievance filing process was often covered in the resident council meetings for those who attended and for everyone else there were signs posted and grievance forms located in the main lobby. SSD further stated any resident could ask her for assistance and she would provide a grievance form and help the resident fill it out. During observation and interview on 2/13/25 at 10:23 a.m., there were no grievance forms within sight or public access in the main lobby. Reception desk personnel (RDP) stated there were usually pamphlets describing the grievance process and grievance forms on a small table located on one side of the lobby. RDP stated there were none their now due to not having enough time to any out. RDP stated upon admission the resident should have also received the pamphlet in their admission packet and if they did not have one the resident or family could ask the SSD who would provide one. During interview on 2/13/25 at 11:25 a.m., administrator stated residents should be completing a complaint (grievance) form when concerns could not be easily resolved. Administrator stated residents and families could pick up a complaint form at the front desk and at all of the nursing stations and that anyone could request assistance in completing the form from staff or SSD. Administrator confirmed there was	F 585	grievance forms are located via an in-person meeting by 3/6/2025. Updated signage was created and posted in the shadow boxes found upon entrance at each unit on 3/4/25. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

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F 585	Continued From page 13 nowhere in the facility to drop of the completed form anonymously but though perhaps there was a way to complete a grievance form anonymously online through the facility website. During interview on 2/13/25 at 11:56 a.m., registered nurse (RN)-B stated if the resident had a concern, he would report it to the supervisor and that there were also forms they could give the resident to complete. RN- B looked around the nurses station as well as the small office behind the nurses station and was unable to locate a grievance form. RN-B stated he would have to refer the resident to the front lobby to retrieve a form since there were none on the unit. Facility pamphlet, Problem Resolution and Grievance Procedure dated 12/21, instructed resident or family to complete the form and then, "Sign the form" and "Present the form to the grievance official as identified in the grievance procedure." The form identified that for a grievance regarding the facility, to "Return to Social Worker or Administrator."	F 585			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684			3/6/25

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F 684	Continued From page 14 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to notify the physican of a change in condition for 1 of 2 residents (R6) with a significant weight gain. Findings include: R6's quarterly Minimum Data Set (MDS) dated 12/26/24, indicated intact cognition and diagnoses of central cord syndrom, spinal stenosis, and chronic pain syndrom. It further indicated R6 required substantial assistance with most activites of daily (ADL) and mobility. R6's physician's orders dated 2/5/25, indicated weekly weights to notify the physician for greater than (>) 5 pound weight gain in a week, (every evening shift every Wednesday) for edema. R6's care plan dated 12/20/24, indicated a nutritional diagnoses of obesity class III related to excessive calorie intake with an intervention to monitor changes in weight. R6's treatment administration record (TAR) for the month of February, indicated on 2/5/25, R6 weighed 397.5 pounds (lbs) and on 2/12/25 weighed 406.1 lbs. This was a weight gain of 8.6 lbs. in one week. R6's progress notes and electronic medication administration report (emar) notes for the month of February lacked documentation of the	F 684	F684 (S/S D): Quality of Care 1.The medical record of the affected resident (R6) was reviewed with the physician on 3/6/25. 2.All residents with a significant weight change have the potential to be affected by this deficient practice. 3.To ensure systemic changes are sustained, all staff will be provided with education on notifying the physician of change in condition with a focus on significant weight loss/gain via an in-person meeting by 3/6/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. Of note, the registered dietician reviews weight changes that trigger as significant on a daily basis and brings findings to the interdisciplinary team on a weekly basis. 5.Compliance Date 3/6/2025.		

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F 684	Continued From page 15 physician being notified of a change in condition regarding the resident weight gain of 8.6 lbs. in one week. During interview on 2/13/25 at 10:25 a.m., RN-B verified R6's TAR indicated a weight gain of 8.6 lbs. in a week but felt they were using the wrong size sling to weigh R6 so he wanted to re-weigh her. RN-B further stated he did not re-weigh her right away because the NA (unknown) was leaving for the evening he was scheduled to come back the next day, so they would just reweigh R6 then. RN-B verified there was no documentation and the provider had not been notified. RN-B stated they would re-weigh her this evening. R6's progress note dated 2/13/2025 at 12:23 p.m., indicated a change in condition as evidenced by edema (new or worsening) and shortenss of breath (SOB) that appears different than usual. It further included a weight of 406.1 lbs. and a recommendation to send R6 to the hosptial for evaluation. During interview on 2/13/25 at 2:49 p.m., RN-F stated there's a reason why the physician ordered weekly weights so if there was a problem with the resident's weight, they should be re-weighed right away, notify the provider, and document. During interview on 2/14/25 at 8:42 a.m., RN-I stated if a resident needed to be re-weighed it should be completed right away, the provider should be notified if there was a problem, and documentation should occur. During interview on 2/14/25 at 8:52 a.m., LPN-B stated if a resident needed to be re-weighed for	F 684			

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F 684	Continued From page 16 some reason, it should be done as soon as possible. If there was still an issue he would notify the provider and document it. During interview on 2/14/25 9:16 a.m., RN-A stated if a resident needed to be re-weighed, it should be done right away and if there was an issue they would notify the provider and document. During interview on 2/14/25 at 10:15 a.m. the director of nursing (DON) stated if a resident needed to be re-weighed it should be done as soon as possible and if there's a problem, the physician should be notified, and it should be documented. A facility policy regarding weighing residents was requested and received however it did not pertain to the citation.	F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686			3/6/25

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F 686	Continued From page 17 by: Based on observation, interview, and document review, the facility failed to ensure pressure ulcer (PU) prevention interventions were in place for 1 of 2 residents (R66) reviewed for pressure ulcers. Findings include: R66's admission Minimum Data Set (MDS) dated 1/27/25, indicated R66 was cognitively intact, required partial to moderate assistance with mobility and most activities of daily living (ADLs), had one or more unhealed PU and at risk for developing more, and did not exhibit rejection of care behaviors. R66's diagnoses included congestive heart failure (CHF), type 2 diabetes mellitus, and dementia without behavioral, psychotic, or mood disturbance. R66's care plan dated 1/23/25, indicated R66 had an actual impairment to skin integrity due to diagnoses and had potential for further PU development due to decreased mobility. The care plan instructed staff to elevate heels off bed with heel protector boot to left leg. R66's Braden assessment (predicting pressure sore risk) dated 2/11/25, indicated R66 was at moderate risk for developing pressure sores. Intervention guide for moderate risk included heel protection. R66's physician order summary printed 2/13/25, indicated, "Bilateral heels: Elevate Heels with heel suspension boots at all times." R66's February care card indicated, "Elevate legs and feet when sitting. Bilateral heels: Elevate heels with heel suspension boots at all times."	F 686	F686 (S/S D): Treatment/Svcs to Prevent/Heal Pressure Ulcers 1.The pressure ulcer on affected resident (R66) was healed on 2/13/25. 2.All residents with pressure ulcers have the potential to be affected by this deficient practice. These residents were reviewed by 3/6/25 to ensure their care plan and treatment orders adequately reflected the treatments as ordered. 3.To ensure systemic changes are sustained, all staff will be provided with education on providing treatments as ordered with a focus on interventions to prevent/heal pressure ulcers via an in-person meeting by 3/14/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. Of note, the interdisciplinary team reviews all wounds on a weekly basis. 5.Compliance Date 3/6/2025.		

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F 686	Continued From page 18 The care card indicated sign off two shifts per day and had been signed as completed for two shifts per day for each day in February. The care card did not indicate R66 refused at any time. R66's Wound Evaluation and Management Summary dated 2/6/25, indicated, "Patient has wound on her left lateral leg; left shin; left heel." The summary further indicated, "Stage 3 pressure wound of the left heel full thickness ...recommendations: off-load wound; float heels in bed; pressure off-loading boot; elevate legs" During observation on 2/10/25 at 5:03 p.m., R66 was sleeping in her recliner, with legs elevated and feet resting directly on footrest. Pressure reducing blue boot not being used and sitting on R66's bed. During interview on 2/10/25 at 6:13 p.m., R66 stated the boot was supposed to be on her left foot but staff did not usually apply it. R66 stated she did not refuse when staff offered to place the boot. During observation on 2/12/25 at 7:33 a.m., registered nurse (RN)-J answered R66's call light. R66 requested assistance to the bathroom. RN-J assisted R66 to a standing position and pivot and transfer to wheelchair and into bathroom. After toilet use, RN-J assisted R66 back to the recliner. R66 raised the footrest. RN-J did not offer any pillows or to place the boot and left R66's room. During interview on 2/12/25 at 8:00 a.m., R66 stated did not have the boot on at all during the night. During observation on 2/12/25 at 8:04 a.m., RN-J			F 686			

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F 686	Continued From page 19 re-entered R66's room to provide a water pitcher and again left the room without offering to don the boot or place pillows under R66's legs to float heels. During observation on 2/12/25 at 1:52 p.m., R66 was in bed with heels resting directly on the mattress. The blue boot was sitting on top of R66's cabinet-not in use. During observation on 2/13/25 at 8:09 a.m., R66 was in bed with heels resting directly on the mattress. The blue boot was sitting on top of R66's cabinet and not in use. During observation and interview on 2/13/25 at 8:22 a.m., nursing assistant (NA)-C confirmed R66's boot was not currently on her. NA-C further stated she had checked on R66 at the start of her shift and the boot was not on R66 at that time either and that her heels were not floated with pillows either. NA-C stated could not remember the last time she saw R66 using the blue boot. During interview on 2/13/25 at 8:27 a.m., RN-F stated resident's care plans should be followed. If R66's care plan instructed staff to ensure her heels were floated or in the boot, that staff should be doing so. RN-F stated was ultimately the nurse's responsibility to ensure this was being done. RN-F stated R66 had current wounds and was at risk for developing more and should have her heels protected. RN-F stated any refusals by residents should be documented in the electronic medical record (EMR). During observation and interview on 2/13/25 at 8:45 a.m., RN-C stated orders and care plans should be followed and expectation for R66's heel	F 686			

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F 686	Continued From page 20 to be protected and not resting on the bed. RN-C stated any care refusals by residents should be documented. During observation and interview on 2/13/25 at 8:54 a.m., RN-C confirmed and stated R66's heels were not currently being off-loaded with a boot or any pillows. During interview on 2/13/25 at 9:13 a.m., wound doctor stated R66's heel wound was healed but would continue to recommend her heel be off loaded and protected with the use of the blue boot as long as a resident in the facility. During interview on 2/13/25 at 10:54 a.m., director of nursing (DON) stated expectation residents should have pressure relieving boots on as ordered and any refusals should be documented. Facility policy Pressure Ulcers-R/S, LTC, Therapy & Rehab dated 3/7/24, indicated, "A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing."	F 686			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690			3/6/25

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F 690	Continued From page 21 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a urinary catheter was secured to facilitate urine flow and positioned below the bladder for 1 of 1 resident reviewed for catheter cares. ensure the proper use of a catheter for 1 of 1 resident (R68). Findings include: R68's annual Minimum Data Set (MDS) dated 12/12/24, indicated moderately impaired cognition and diagnoses of chronic kidney disease and retention of urine. It further indicated R68	F 690	F690 (S/S D): Bowel/Bladder Incontinence 1.The physician for the affected resident (R68) reviewed the catheter order on 2/27/25. The care plan of the affected resident (R68) was reviewed and updated on 3/5/25 and the affected resident (R68) and his representative were educated on the risks/benefits on 3/5/2025. 2.All residents with indwelling catheters have the potential to be affected by this deficient practice. These residents were reviewed by 3/6/25 to ensure their care		

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F 690	Continued From page 22 required setup/cleanup assistance with toileting, was independent with mobility, had a catheter, was occasionally incontinent of bowel. R68's physician's order dated 1/9/25, indicated Foley catheter:16F catheter 10cc balloon change as necessary every 45-90 days, as needed for urinary retention. The order lacked documentation R68's leg bag did not need to be positioned below the bladder. R68's care plan dated 10/16/24, indicated R68 had an indwelling catheter related to an acute kidney injury (AKI) evidenced by urinary retention. It further indicated an intervention to monitor/document for pain/discomfort due to catheter. R68's care plan lacked interventions to ensure the catheter was positioned below the bladder. During observation on 2/10/25 at 7:44 a.m., R68 was lying in bed, wearing a leg catheter bag which was attached to his leg and even with his bladder. The leg bag was over halfway full of clear amber colored urine and there was urine in the tubing in between his bladder and the leg bag. During observation and interview on 2/10/25 at 7:58 a.m., nursing assistant (NA)-B stated she started her shift at 6:30 a.m. and hadn't done anything with R68's catheter. NA-B verified R68's drainage bag was not below his bladder and stated R68 wears a leg drainage bag all the time because he walked around a lot. During interview on 2/13/25 at 2:49 p.m., RN-F verified when a resident had a catheter, the drainage bag should be positioned below the bladder and if for some reason it wasn't able to	F 690	plans and orders reflected the treatment as ordered. 3.To ensure systemic changes are sustained, all staff will be provided with education on catheter care via an in-person meeting by 3/14/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

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F 690	Continued From page 23 be, the provider should be notified. During interview on 2/10/25 at 8:04 a.m., RN-G stated R68 used a leg bag all the time for his safety and because he walks around a lot. RN-G stated he wasn't sure if the physician's order indicated it was okay for R68's leg bag all the time. During interview on 2/10/25 at 8:21 a.m. RN-H stated R68 wears a leg bag all the time per his preference and preferences should be care planned. During interview on 2/13/25 at 10:25 a.m., RN-B stated a resident's catheter drainage bag should be positioned below the bladder but if for some reason they need to wear a leg bag all the time, the provider should be notified in order to consult with them. During interview on 2/14/25 at 8:42 a.m., RN-I stated catheter drainage bags are supposed to be positioned below the bladder and anytime nursing staff are doing something different from what the physician's order indicates, they should notify the physician. This is important, so everyone knows why they are doing it. During interview on 2/14/25 at 8:52 a.m. licensed practical nurse (LPN)-B stated catheter drainage bags were supposed to be positioned below the bladder and if there was a reason why it wasn't able to be, nursing staff were responsible for notifying the provider. LPN-B further stated a catheter should be treated like a medication, when it was used outside it's intended purpose, it was important to notify the provider because they should be involved.	F 690			

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F 690	Continued From page 24 During interview on 2/14/25 at 10:15 a.m., the director of nursing (DON) stated nurses were responsible for checking with the provider in order to change the way the catheter was being used. In this case, the catheter leg drainage bag was being worn all the time (even during the night while sleeping) and wasn't positioned below the bladder. The DON further indicated it was R68's preference to use the leg and preferences should be care planned and documented. A facility policy regarding catheter care dated 7/30/24, indicated leg bags may be used with a physician's order, catheter tubing is secured to the residents leg, coiled on bed with no kinks or obstructions and the rest of the tubing should be in a straight line into urinary drainage bag. Non-obstructed downhill flow is always maintained. When catheters with technical designs other than downhill flow are used, manufacturers instructions are followed. Always make sure drainage bag and tubing remain below level of catheter, bladder and coil tubing to promote drainage.	F 690			
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure beverages were served in the appropriate consistency for 1	F 805	F805 (S/S D): Food in Form to Meet Individual Needs 1.The care plan and diet orders of the		3/6/25

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F 805	Continued From page 25 of 1 resident (R12) reviewed for therapeutic diets. Findings include: R12's State Optional Minimum Data Set (MDS) dated 2/5/25, indicated R12 had severe cognitive impairment, was independent after set-up with meals, worked with speech therapy from 1/15/25 through 1/27/25, and did not exhibit rejection of care behavior. R12's diagnoses included pneumonitis due to inhalation of food and vomit, other symptoms and signs concerning food and fluid intake, and type 2 diabetes. R12's annual MDS dated 1/19/25, indicated R12 required " Mechanically altered diet - require change in texture of food or liquids [e.g. pureed food, thickened liquids]." R12's nutrition care area assessment (CAA) dated 1/19/25, indicated R12 required pureed textures and mildly thick liquids due to dysphagia. R12's care plan last revised 2/6/25, indicated R12 was at risk for altered nutrition/hydration and interventions included, "Resident has order for thickened liquids." The care plan further instructed staff to monitor closely for swallowing difficulties. R12's Dietician Assessment dated 1/14/25, indicated, "Diet: CCHO diet/pureed textures/mildly thick [level 2] liquids." R12's Kardex dated 2/10/25, indicated, "Mildly Thick consistency. All fluids must be thickened including water, coffee, pop." R12's physician order dated 1/14/25, indicated,	F 805	affected resident (R12) was reviewed on 2/10/25. Of note, the diet of the affected resident (R12) was upgraded to thin liquids on 3/4/25. 2.All residents receiving modified diets have the potential to be affected by this deficient practice. These residents were reviewed by 3/6/25 to ensure their care plans and orders reflected the treatment as ordered. 3.To ensure systemic changes are sustained, all staff will be provided with education on providing modified diets are ordered via an in-person meeting by 3/14/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

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F 805	Continued From page 26 "CCHO [controlled carbohydrate] diet 4 Pureed texture, 2 Mildly Thick consistency." R12's Outpatient Video Fluoroscopic Swallowing Study (VFSS) dated 2/10/25, indicated, "Plan/Goals: SLP [speech language pathologist] recommending modified oral diet consisting of IDDSI 6 Soft & Bite Sized Foods and IDDSI 2 Mildly Thick Liquids ...Based on today's findings, patient would benefit from a repeat instrumental assessment to assist in diet upgrades given silent aspiration of thin liquids observed during today's VFSS." R12's medical record lacked evidence of a risks and benefits for non-compliance of ordered diet. During observation and interview on 2/10/25 at 2:04 p.m., a dry erase board just inside the entrance of R12's room indicated, "pureed diet mildly thick liquid." R12 stated she just had another swallow study done today and was on a modified diet. R12 stated she did not like the pureed diet and thickened liquids, but that was what they provided. R12 stated risks and benefits of not following the prescribed diet had never been discussed. There was a can of soda on her bedside table out of reach with a straw that she stated was empty and wanted another one. During observation on 2/10/25 at 2:18 p.m., R12 activated call light to request a beverage. At 2:19 p.m., the administrator entered R12's room and inquired about her request. R12 stated she wanted a can of soda from the refrigerator in her room. Administrator removed a can of soda, opened it, and provided a new straw. Administrator handed R12 the soda, pushed the bedside table close to the bed and discarded the	F 805			

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F 805	Continued From page 27 old can of soda. Administrator left the room. R12 confirmed the soda was 'normal' and had not been thickened. During interview on 2/10/25 at 2:59 p.m., registered nurse (RN)-A stated R12 required a diabetic diet, mechanically altered and thickened liquids. During interview on 2/10/25 at 3:00 p.m., RN-C stated R12 was on a CCHO diet with pureed and mildly thick consistency. RN-C stated all liquids should be thickened and that the family had supplied R12 with soda and that they know it should be thickened. RN-C stated if staff provide R12 with one of the sodas, they should be thickening it prior to serving. RN-C stated R12 could sometimes refuse but staff should always offer and encourage her to take thickened liquids due to her swallowing issues. During interview on 2/10/25 at 3:08 p.m., administrator stated she thought R12 was on thickened liquids but would have to refer to her orders to be sure. Administrator stated, "I think she is non-compliant with her diet ...but yes if she had thickened liquid diet ordered, then I should have offered to thicken it." Administrator further stated if R12 refused the ordered diet, R12 should be educated on risks and benefits. During interview on 2/12/25 at 9:46 a.m., family member (FM)-A stated she provided R12 with the soda but understood that it had to be thickened and would expect staff to be doing that prior to giving to R12 due to her risk of aspiration. FM-A stated a risks and benefits of not following the prescribed diet had never been discussed.	F 805			

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F 805	Continued From page 28 During interview on 2/12/25 at 1:27 p.m. SLP stated R12 had just completed a swallow study a couple days earlier and that her diet recommendation continued as mildly thick liquids due to silent aspiration noted on study. During interview on 2/12/25 at 1:37 p.m., director of nursing (DON) stated expect residents to received diets as ordered with the correct texture and liquid consistency. R12 should have received mildly thickened liquids as ordered. Facility policy Acceptance of Therapeutic and/or Texture-Modified Diet-Food and Nutrition Service dated 5/14/24, indicated, "acceptance of therapeutic or texture-modified diet and dietary interventions when there is a nutritional or swallowing concern." The policy further indicated staff would provide appropriate diet unless resident or resident representative refused, in which case evidence of refusals, education provided, and risks and benefits discussion would be documented in the resident's medical record and an order for a liberalized diet would have to be obtained.	F 805			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812			3/6/25

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F 812	Continued From page 29 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishwasher temperatures were within range to ensure resident dishes were sanitized for 4 of 5 unit (Boundary Waters, Arrowhead, Lakes, Woodland) kitchenettes that housed and utilized dishwashers. In addition, the facility failed to maintain the coffee machine in a sanitary manner to prevent potential food-borne illness. These practices had the potential to affect all residents residing in these units. Findings include: Dishwasher Temperatures: During observation on 2/12/25 at 10:36 a.m., dishwasher temperature log in the Lakes unit kitchenette had temperatures documented for the following dates/meals (breakfast-B, lunch-L, dinner-D): 1/31/25-L, 2/1/25-B, L D, 2/2/25-B and L, and 2/4/25-L. During interview on 2/12/25 at 10:40 a.m., dietary aide (DA)-A stated it was the responsibility of the dietary staff working in the kitchenette for that shift to check and document the dishwasher temperatures. DA-A stated she thought they needed to be checked at least twice a day and confirmed the log in the Lakes unit was not	F 812	F812 (S/S E) Food Procurement 1.All residents have the potential to be affected by this deficient practice. 2.All residents have the potential to be affected by this deficient practice. 3.To ensure systemic changes are sustained, all staff will be provided with education on recording dishwasher temperatures and kitchenette cleanliness via an in-person meeting by 3/6/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on random units. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2025
FORM APPROVED
OMB NO. 0938-0391

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F 812	Continued From page 30 complete or up to date. During observation on 2/12/25 at 10:50 a.m., Woodland unit kitchenette dishwasher log had temperatures documented for the following dates/meals: 1/31/25-L, 2/1/25-B, L, D, 2/2/25-B, L, D, 2/4/25-L, and 2/10/25-L. During observation on 2/12/25 at 11:34 a.m., Boundary Waters unit kitchenette dishwasher log had temperatures documented for the following dates/meals: 2/1-B,L,D, 2/2-B,L,D, 2/3-D, 2/4-D, 2/5-B,L,D, 2/6-B, 2/7B,L, 2/11-B,L,D. During observation on 2/12/25 at 11:37 a.m., Arrowhead unit kitchenette dishwasher log had temperatures documented for the following dates/meals: 2/1-B,L,D, 2/2-B,L,D, 2/4-D, 2/5-B,L,D, 2/6-L, 2/7-B,L, 2/11-B,L,D, 2/12-B. During interview on 2/13/25 at 11:17 a.m., KM stated expectation for staff to check wash and rinse cycle temperatures on the unit dishwashers twice a day and document the findings on a dishwasher log and take appropriate action if not up to proper temperature. Coffee maker cleanliness: During observation on 2/12/25 at 10:36 a.m., the coffee/hot water dispenser is dirty with splashed liquids- the overflow basin has water with some white foamy substance floating on it. During interview on 2/12/25 at 10:40 a.m., DA-A stated it was the kitchen staff's responsible for maintaining and cleaning the unit kitchenettes. SA-A confirmed the coffee reservoir was not clean and stated it looked like mold floating on	F 812			

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F 812	Continued From page 31 top of the liquid. DA-A stated that the coffee maker was supposed to be cleaned daily. During interview on 2/12/25 at 11:45 a.m., kitchen manager (KM) stated the dietary staff serving meals in each of the kitchenettes were responsible to clean and maintain a sanitary environment each shift. Staff had a checklist and were expected to sign and date when each task was completed. KM confirmed the Lakes unit kitchenette coffee maker reservoir was full of liquid and had an unknown white and black foamy substance floating on top of the liquid. KM stated it appeared that the reservoir had not been cleaned in 7-14 days. KM further confirmed the Lakes Kitchenette cleaning log had not been signed off as having the coffee maker cleaning completed. During interview on 2/13/25 at 12:09 p.m., administrator stated expectation for dishwasher temperatures be monitored and documented daily to ensure proper temperatures for sanitation. Administrator further stated expectation for staff to ensure kitchenettes were maintained and cleaned daily to ensure proper sanitation conditions. Facility Cleaning list (TASK) sheet for Lakes unit Kitchenette dated 2/9/25 - 2/15/25 indicated, "Sanitize all counters Clean Coffee [sic] MACHINE CHECK COFFEE FOR REPLACEMENT" and "DISH WASHING & CLEANING STARS [sic] IMMEDIATELY AFTER, (BREAKFAST (LUNCH & (DINNER) THERE IS NO WAITING PERIOD." The list further indicated, "PLEASE MAKE SURE YOU ARE DOING YOUR CLEANING & POSTED JOB DETAIL. ALL DIETARY EMPLOYEES MUST			F 812			

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F 812	Continued From page 32 DOCUMENT TEMPERATURES. COMPLETE POSTED FLOOR ASSIGNMENTS/JOB DETAIL, PLEASE INITIAL ASSIGNED JOB DETAIL WHEN DONE." Facility policy Ware Washing-Mechanical and Manual-Food and Nutrition dated 3/25/24, indicated good ware washing (cleaning and sanitizing of utensils and food-contact surfaces of equipment) was to promote good practice regarding prevention of foodborne illness. The policy indicated, "Food and nutrition employees ensure that food preparation equipment, dishes and utensils are effectively cleaned, sanitized to destroy potential disease carrying organisms." The policy further indicated temperatures of the wash and rinse cycle should be monitored and documented on the Dish Machine Temperature Log. Facility policy Cleaning Schedule-Food and Nutrition Services dated 11/21/24, indicated employees were responsible for knowing and completing assigned cleaning duties and to document completion on the Cleaning Schedule log each day. "Guidelines for Kitchen and Equipment Cleaning ...1. Check each equipment item in kitchen for cleanliness and that it is in good repair."			F 812			

Minnesota Department of Health

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2 000	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 2/10/25-2/14/25 , a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following licensing orders are issued at 0900, 1015, 1565, 1800, and 1925. Please indicate in your electronic plan of	2 000			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/25

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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed during the survey: H52796841C (MN00110396) H52797041C (MN00106775) H52797042C (MN00106882) H52797043C (MN00103564) H52797044C (MN00102143) H52797623C (MN00110719) (MN00110734) 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 surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic	2 000			

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2 000	Continued From page 2 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. http://www.health.state.mn.us/divs/fpc/profinfo/info.html . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the	2 900			3/6/25

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2 900	Continued From page 3 comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure pressure ulcer (PU) prevention interventions were in place for 1 of 2 residents (R66) reviewed for pressure ulcers. Findings include: R66's admission Minimum Data Set (MDS) dated 1/27/25, indicated R66 was cognitively intact, required partial to moderate assistance with mobility and most activities of daily living (ADLs), had one or more unhealed PU and at risk for developing more, and did not exhibit rejection of care behaviors. R66's diagnoses included congestive heart failure (CHF), type 2 diabetes mellitus, and dementia without behavioral, psychotic, or mood disturbance. R66's care plan dated 1/23/25, indicated R66 had an actual impairment to skin integrity due to diagnoses and had potential for further PU	2 900	2900 - MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers (State Nursing Home Licensure) 1.The pressure ulcer on affected resident (R66) was healed on 2/13/25. 2.All residents with pressure ulcers have the potential to be affected by this deficient practice. These residents were reviewed by 3/6/25 to ensure their care plan and treatment orders adequately reflected the treatments as ordered. 3.To ensure systemic changes are sustained, all staff will be provided with education on providing treatments as ordered with a focus on interventions to prevent/heal pressure ulcers via an in-person meeting by 3/14/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI		

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2 900	Continued From page 4 development due to decreased mobility. The care plan instructed staff to elevate heels off bed with heel protector boot to left leg. R66's Braden assessment (predicting pressure sore risk) dated 2/11/25, indicated R66 was at moderate risk for developing pressure sores. Intervention guide for moderate risk included heel protection. R66's physician order summary printed 2/13/25, indicated, "Bilateral heels: Elevate Heels with heel suspension boots at all times." R66's February care card indicated, "Elevate legs and feet when sitting. Bilateral heels: Elevate heels with heel suspension boots at all times." The care card indicated sign off two shifts per day and had been signed as completed for two shifts per day for each day in February. The care card did not indicate R66 refused at any time. R66's Wound Evaluation and Management Summary dated 2/6/25, indicated, "Patient has wound on her left lateral leg; left shin; left heel." The summary further indicated, "Stage 3 pressure wound of the left heel full thickness ...recommendations: off-load wound; float heels in bed; pressure off-loading boot; elevate legs" During observation on 2/10/25 at 5:03 p.m., R66 was sleeping in her recliner, with legs elevated and feet resting directly on footrest. Pressure reducing blue boot not being used and sitting on R66's bed. During interview on 2/10/25 at 6:13 p.m., R66 stated the boot was supposed to be on her left foot but staff did not usually apply it. R66 stated she did not refuse when staff offered to place the	2 900	committee for further recommendations. Of note, the interdisciplinary team reviews all wounds on a weekly basis. 5.Compliance Date 3/6/2025.		

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2 900	Continued From page 5 boot. During observation on 2/12/25 at 7:33 a.m., registered nurse (RN)-J answered R66's call light. R66 requested assistance to the bathroom. RN-J assisted R66 to a standing position and pivot and transfer to wheelchair and into bathroom. After toilet use, RN-J assisted R66 back to the recliner. R66 raised the footrest. RN-J did not offer any pillows or to place the boot and left R66's room. During interview on 2/12/25 at 8:00 a.m., R66 stated did not have the boot on at all during the night. During observation on 2/12/25 at 8:04 a.m., RN-J re-entered R66's room to provide a water pitcher and again left the room without offering to don the boot or place pillows under R66's legs to float heels. During observation on 2/12/25 at 1:52 p.m., R66 was in bed with heels resting directly on the mattress. The blue boot was sitting on top of R66's cabinet-not in use. During observation on 2/13/25 at 8:09 a.m., R66 was in bed with heels resting directly on the mattress. The blue boot was sitting on top of R66's cabinet and not in use. During observation and interview on 2/13/25 at 8:22 a.m., nursing assistant (NA)-C confirmed R66's boot was not currently on her. NA-C further stated she had checked on R66 at the start of her shift and the boot was not on R66 at that time either and that her heels were not floated with pillows either. NA-C stated could not remember the last time she saw R66 using the blue boot.	2 900			

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2 900	Continued From page 6 During interview on 2/13/25 at 8:27 a.m., RN-F stated resident's care plans should be followed. If R66's care plan instructed staff to ensure her heels were floated or in the boot, that staff should be doing so. RN-F stated was ultimately the nurse's responsibility to ensure this was being done. RN-F stated R66 had current wounds and was at risk for developing more and should have her heels protected. RN-F stated any refusals by residents should be documented in the electronic medical record (EMR). During observation and interview on 2/13/25 at 8:45 a.m., RN-C stated orders and care plans should be followed and expectation for R66's heel to be protected and not resting on the bed. RN-C stated any care refusals by residents should be documented. During observation and interview on 2/13/25 at 8:54 a.m., RN-C confirmed and stated R66's heels were not currently being off-loaded with a boot or any pillows. During interview on 2/13/25 at 9:13 a.m., wound doctor stated R66's heel wound was healed but would continue to recommend her heel be off loaded and protected with the use of the blue boot as long as a resident in the facility. During interview on 2/13/25 at 10:54 a.m., director of nursing (DON) stated expectation residents should have pressure relieving boots on as ordered and any refusals should be documented. Facility policy Pressure Ulcers-R/S, LTC, Therapy & Rehab dated 3/7/24, indicated, "A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing."	2 900			

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2 900	Continued From page 7	2 900			
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.				
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishwasher temperatures were within range to ensure resident dishes were sanitized for 4 of 5 unit	21015			3/6/25
			21015 - MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi (State Nursing Home Licensure) 1.All residents have the potential to be		

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21015	Continued From page 8 (Boundary Waters, Arrowhead, Lakes, Woodland) kitchenettes that housed and utilized dishwashers. In addition, the facility failed to maintain the coffee machine in a sanitary manner to prevent potential food-borne illness. These practices had the potential to affect all residents residing in these units. Findings include: Dishwasher Temperatures: During observation on 2/12/25 at 10:36 a.m., dishwasher temperature log in the Lakes unit kitchenette had temperatures documented for the following dates/meals (breakfast-B, lunch-L, dinner-D): 1/31/25-L, 2/1/25-B, L D, 2/2/25-B and L, and 2/4/25-L. During interview on 2/12/25 at 10:40 a.m., dietary aide (DA)-A stated it was the responsibility of the dietary staff working in the kitchenette for that shift to check and document the dishwasher temperatures. DA-A stated she thought they needed to be checked at least twice a day and confirmed the log in the Lakes unit was not complete or up to date. During observation on 2/12/25 at 10:50 a.m., Woodland unit kitchenette dishwasher log had temperatures documented for the following dates/meals: 1/31/25-L, 2/1/25-B, L, D, 2/2/25-B, L, D, 2/4/25-L, and 2/10/25-L. During observation on 2/12/25 at 11:34 a.m., Boundary Waters unit kitchenette dishwasher log had temperatures documented for the following dates/meals: 2/1-B,L,D, 2/2-B,L,D, 2/3-D, 2/4-D, 2/5-B,L,D, 2/6-B, 2/7B,L, 2/11-B,L,D. During observation on 2/12/25 at 11:37 a.m.,	21015	affected by this deficient practice. 2.All residents have the potential to be affected by this deficient practice. 3.To ensure systemic changes are sustained, all staff will be provided with education on recording dishwasher temperatures and kitchenette cleanliness via an in-person meeting by 3/6/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on random units. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

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21015	Continued From page 9 Arrowhead unit kitchenette dishwasher log had temperatures documented for the following dates/meals: 2/1-B,L,D, 2/2-B,L,D, 2/4-D, 2/5-B,L,D, 2/6-L, 2/7-B,L, 2/11-B,L,D, 2/12-B. During interview on 2/13/25 at 11:17 a.m., KM stated expectation for staff to check wash and rinse cycle temperatures on the unit dishwashers twice a day and document the findings on a dishwasher log and take appropriate action if not up to proper temperature. Coffee maker cleanliness: During observation on 2/12/25 at 10:36 a.m., the coffee/hot water dispenser is dirty with splashed liquids- the overflow basin has water with some white foamy substance floating on it. During interview on 2/12/25 at 10:40 a.m., DA-A stated it was the kitchen staff's responsible for maintaining and cleaning the unit kitchenettes. SA-A confirmed the coffee reservoir was not clean and stated it looked like mold floating on top of the liquid. DA-A stated that the coffee maker was supposed to be cleaned daily. During interview on 2/12/25 at 11:45 a.m., kitchen manager (KM) stated the dietary staff serving meals in each of the kitchenettes were responsible to clean and maintain a sanitary environment each shift. Staff had a checklist and were expected to sign and date when each task was completed. KM confirmed the Lakes unit kitchenette coffee maker reservoir was full of liquid and had an unknown white and black foamy substance floating on top of the liquid. KM stated it appeared that the reservoir had not been cleaned in 7-14 days. KM further confirmed the Lakes Kitchenette cleaning log had not been	21015			

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21015	Continued From page 10 signed off as having the coffee maker cleaning completed. During interview on 2/13/25 at 12:09 p.m., administrator stated expectation for dishwasher temperatures be monitored and documented daily to ensure proper temperatures for sanitation. Administrator further stated expectation for staff to ensure kitchenettes were maintained and cleaned daily to ensure proper sanitation conditions. Facility Cleaning list (TASK) sheet for Lakes unit Kitchenette dated 2/9/25 - 2/15/25 indicated, "Sanitize all counters Clean Coffee [sic] MACHINE CHECK COFFEE FOR REPLACEMENT" and "DISH WASHING & CLEANING STARS [sic] IMMEDIATELY AFTER, (BREAKFAST (LUNCH & (DINNER) THERE IS NO WAITING PERIOD." The list further indicated, "PLEASE MAKE SURE YOU ARE DOING YOUR CLEANING & POSTED JOB DETAIL. ALL DIETARY EMPLOYEES MUST DOCUMENT TEMPERATURES. COMPLETE POSTED FLOOR ASSIGNMENTS/JOB DETAIL, PLEASE INITIAL ASSIGNED JOB DETAIL WHEN DONE." Facility policy Ware Washing-Mechanical and Manual-Food and Nutrition dated 3/25/24, indicated good ware washing (cleaning and sanitizing of utensils and food-contact surfaces of equipment) was to promote good practice regarding prevention of foodborne illness. The policy indicated, "Food and nutrition employees ensure that food preparation equipment, dishes and utensils are effectively cleaned, sanitized to destroy potential disease carrying organisms." The policy further indicated temperatures of the wash and rinse cycle should be monitored and	21015			

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21015	Continued From page 11 documented on the Dish Machine Temperature Log. Facility policy Cleaning Schedule-Food and Nutrition Services dated 11/21/24, indicated employees were responsible for knowing and completing assigned cleaning duties and to document completion on the Cleaning Schedule log each day. "Guidelines for Kitchen and Equipment Cleaning ...1. Check each equipment item in kitchen for cleanliness and that it is in good repair." SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen, kitchenettes and dining areas. The facility should also ensure appropriate cleaning of equipment occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015			
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and	21565			3/6/25

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21565	Continued From page 12 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medication assessment (SAM) was completed to allow residents to safely administer their own medications for 1 of 1 (R140) resident observed with medications at bedside. Findings include: R140's admission Minimum Data Set (MDS) dated 2/10/25, indicated intact cognition and diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). If further indicated R140 required partial assistance with most activities of daily living (ADL). R140's physician's orders dated 2/5/25, indicated Breo Ellipta Inhalation Aerosol Powder Breath Activated 200-25 microgram (MCG)/ACT (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day for chronic obstructive pulmonary disease (COPD). Rinse mouth after each use. Notify the nurse manager if R140 refuses or unable to rinse. It further included an order dated 2/5/25, indicating Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for shortness of breath (SOB). R140's physician's orders lacked an order to self administer medication. R140's medical record lacked an assessment to	21565	21565 - MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin (State Nursing Home Licensure) 1.The inhalers found in the affected residents (R140) were removed immediately. The affected resident (R140) discharged from the facility of 2/24/25. 2.All residents receiving inhaler treatment have the potential to be affected by this deficient practice. These residents were reviewed by 3/6/25 to ensure that a self-administration of medications (SAMS) assessment was completed if needed. The orders for inhalers for residents not deemed appropriate for self-administration of medications were updated to reflect, Inhaler not to be left at bedside. 3.To ensure systemic changes are sustained, all staff will be provided with education on providing medication as ordered by the physician with a focus on ensuring medications are not left at bedside via an in-person meeting by 3/6/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

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21565	Continued From page 13 self administer medications. R140's care plan lacked documentation R140 was able to self administer his medications. During observation on 2/10/25 at 2:15 p.m., R140 was sitting in his room in his wheelchair. On the nightstand were 3 inhalers, two of which were Breo Ellipta inhalers and one was an albuterol inhaler. During observation and interview on 2/10/25, at 2:18 p.m. registered nurse (RN)-C verified R140 had medications (3 inhalers) at bedside. RN-C also verified R140 was not able to administer his own medications and they should not be kept at bedside or in his room unless he had been assessed for safety and there was a doctor's order, which he didn't have. RN-C explained to R140 that it was important to not keep medications in his room without a lock box in case a resident wandered into his room and decided to take it. During interview on 2/14/25 at 10:15 a.m., the director of nursing (DON) stated in order for a resident to be able to administer their own medications they would need to be assessed to determine if it was safe to do so, and then they would need to obtain a physician's order. The DON further indicated medications should not be kept at bedside even if the resident has been deemed safe to self administer their medications. They need to be kept in a lock box in the resident's room in order to prevent another resident from possibly wandering in there and taking the wrong medications. Also if resident's are self administering their medications without being assessed, they may take the wrong dose or at the wrong time, etc.	21565			

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21565	Continued From page 14 The facility's policy regarding the self administration of medications dated 10/29/24, indicated the procedure for determining if a resident could self adminster their medications was as follows: 1. Complete the Resident Self-Administration of Medications UDA to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process. The interdisciplinary team must determine whether each resident who expresses a desire to self-administer medications can do this safely. It is also recommended that the initial MDS be completed prior to this review. Areas of the MDS that may impact the team ' s decision include B, C, D, E and J. A query could be used by the team to review MDS coding on these and other areas. 2. The interdisciplinary team will determine if the resident has any specific educational needs or if he or she requires any accommodation to selfadminister medication(s). When responding to question 3 - numbers 2 through 6 will create a progress note for Teaching - Resident/Family. 3. The interdisciplinary team will also determine where medications will be stored. This can be at the nurses ' station, in a locked medication cart, a locked compartment or locked drawer in the resident ' s room. If the medication is stored at the resident ' s bedside, an additional key must be kept by nursing employees. 4. The interdisciplinary team will determine the location where the medication will be self-administered. Medication cannot be left within reach of another resident and must be under the control of the resident who is self administering. 5. The interdisciplinary team will determine who	21565			

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21565	Continued From page 15 will document the medication administration (e.g., the resident or the nursing employees). If the resident will be documenting his or her medication, it is recommended that the Resident Self-Administration Record (GSS #261) be used and scanned into 6. The interdisciplinary team ' s determination that the resident can safely selfadminister medications must be documented in the Resident Self- Administration of Medication UDA. 7. A physician ' s order must be obtained prior to the resident self-administering medications. a. The order must be specific to the medications being self-administered (e.g., "Bengay ointment tid prn for leg discomfort. May be kept at bedside for self-administration" or, "May have all oral medications at bedside for self-administration"). Update with new orders as needed. 8. The care plan must indicate which medications the resident is selfadministering, where they are kept, who will document the medication and the location of administration, if applicable. Document quarterly on PN - Care Plan Review. 9. The resident ' s ability to continue to safely self-administer medication must be reviewed during the care planning process. It is recommended that this be done at least quarterly and with any significant change. If the resident is no longer able to self-administer medications safely, the physician must be notified, and medication will then be administered by nursing employees. 10. All medications that the resident stores in his or her room must be reconciled (counted or observed for amount used, e.g., ointments and inhalers) and documented by a licensed nurse at least weekly on the MAR. 11. Medication errors made by the resident during self-administration are not to be counted in the location ' s medication error rate.	21565			

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21565	Continued From page 16 12. Some states have specific rules regarding self-administration of medications. Please check your state regulations for additional information. Periodic verification with the individual state regulations is encouraged due to potential changes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of medications; then provide staff education. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565			
21800	MN St. Statute 144.651 Subd. 4 Patients & Residents of HC Fac. Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable	21800			3/6/25

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21800	Continued From page 17 accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents knew how to file a grievance and that grievance forms were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 4 of 4 residents (R29, R32, R37 and R39) reviewed for grievances. This had the potential to affect all residents residing in the facility. Findings include: On 2/12/25 at 11:00 a.m., a resident council meeting was held with four residents which included R29, R32, R37 and R39. During the resident council meeting, all four residents indicated they were not aware of how to file a grievance or where to find a grievance form. All four residents stated that they knew they could talk to the previous social worker, but since he left none of them felt they could discuss grievances with social services director (SSD).	21800	21800 - MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights (State Nursing Home Licensure) 1.The affected residents (R29, R32, R37 and R39) received re-education on how to file grievances on 3/5/25. 2.All residents have the potential to be affected by this deficient practice. Acrylic brochure holders were purchased on 2/22/25 and installed on 2/26/25 to easily hold blank grievance forms to allow easy access to residents, visitors, and staff. Information on how to file grievances has been added to the monthly resident council meeting agenda. 3.To ensure systemic changes are sustained, all staff will be provided with education on how to assist residents with completing grievances as well as were grievance forms are located via an in-person meeting by 3/6/2025. Updated signage was created and posted in the shadow boxes found upon entrance at		

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21800	Continued From page 18 During interview on 2/13/25 at 9:45 a.m., SSD stated the grievance filing process was often covered in the resident council meetings for those who attended and for everyone else there were signs posted and grievance forms located in the main lobby. SSD further stated any resident could ask her for assistance and she would provide a grievance form and help the resident fill it out. During observation and interview on 2/13/25 at 10:23 a.m., there were no grievance forms within sight or public access in the main lobby. Reception desk personnel (RDP) stated there were usually pamphlets describing the grievance process and grievance forms on a small table located on one side of the lobby. RDP stated there were none their now due to not having enough time to any out. RDP stated upon admission the resident should have also received the pamphlet in their admission packet and if they did not have one the resident or family could ask the SSD who would provide one. During interview on 2/13/25 at 11:25 a.m., administrator stated residents should be completing a complaint (grievance) form when concerns could not be easily resolved. Administrator stated residents and families could pick up a complaint form at the front desk and at all of the nursing stations and that anyone could request assistance in completing the form from staff or SSD. Administrator confirmed there was nowhere in the facility to drop of the completed form anonymously but though perhaps there was a way to complete a grievance form anonymously online through the facility website. During interview on 2/13/25 at 11:56 a.m., registered nurse (RN)-B stated if the resident had	21800	each unit on 3/4/25. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on 5 random residents. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CA			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422		
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21800	Continued From page 19 a concern, he would report it to the supervisor and that there were also forms they could give the resident to complete. RN- B looked around the nurses station as well as the small office behind the nurses station and was unable to locate a grievance form. RN-B stated he would have to refer the resident to the front lobby to retrieve a form since there were none on the unit. Facility pamphlet, Problem Resolution and Grievance Procedure dated 12/21, instructed resident or family to complete the form and then, "Sign the form" and "Present the form to the grievance official as identified in the grievance procedure." The form identified that for a grievance regarding the facility, to "Return to Social Worker or Administrator." Facility policy Grievances, Suggestions or Concerns-Rehab/Skilled, dated 12/2/24, indicated, "A resident has the right to voice grievances orally, in writing and anonymously without discrimination or reprisal." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to greivances to ensure grievances are acted upon and the resident given a resolution to the identified grievance. The director of nursing, social worker, or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure grievacnes are acted upon and the resolution notification is made to the resident and/or family. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs.	21800			

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21800	Continued From page 20	21800			
21925	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights 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 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 MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident and/or resident representative (RR) with a written notice of transfer for 2 of 2 residents (R20,) reviewed for hospitalization.	21925			3/6/25
			21925 - MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights (State Nursing Home Licensure) 1.All residents have the potential to be affected by this deficient practice.		

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21925	Continued From page 21 Findings include: R20's active orders indicated on 1/19/21, patient needed POA to designate decision making. R20's quarterly Minimum Data Set (MDS) dated 1/16/25, identified severely impaired cognition and diagnoses of vascular dementia, schizophrenia, epilepsy, cerebral infarction with hemiplegia and hemiparesis. R20 required total assistance with toileting and transfers. R20's progress notes identified the following: 1. On 9/13/24 at 2:08 a.m., due to a change in condition, she was transferred emergently to the hospital 2. On 12/17/24 at 10:00 a.m., due to a change in condition, she was transferred emergently to the hospital. The progress notes lacked notation that a written notice of transfer was provided to R20 or her resident representative (RR)-A, for either hospitalization. R20's census indicated hospital leave for 9/13/24 through 9/16/24 and 12/17/24 through 12/18/24. R20's electronic medical record (EMR), Point Click Care (PCC), and scanned documents located within the software of On Base, dated 9/13/24 through 12/18/24, lacked documentation of written transfer notice to R20 or RR-A. During an interview on 2/11/25 at 3:25 p.m., licensed practical nurse (LPN)- A and registered nurse (RN)-D stated that bed holds are given to the patient when transferred to the hospital and a	21925	2.All residents have the potential to be affected by this deficient practice. 3.To ensure systemic changes are sustained, all staff will be provided with education on notice requirements before transfers/discharge via an in-person meeting by 3/6/2025. 4.To ensure compliance is maintained, audits will be completed weekly x 4 and monthly x 3 on random units. Results will be brought to the QAPI committee for further recommendations. 5.Compliance Date 3/6/2025.		

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21925	Continued From page 22 copy is provided to the front desk or social services (SSD). During an interview on 2/11/25 at 3:29 p.m., registered nurse (RN)-E, indicated she would discuss with the SSD regarding scanned bed holds and written notification of transfers. During an interview on 2/12/25 at 9:21 a.m., SSD verified R20's RR-A, was notified for hospital transfers verbally in both progress notes. R20 was scheduled to return to the facility before SSD could process a bed hold. The SSD confirmed RR-A was given verbal confirmation for both hospital transfers. Surveyor verified through interview with SSD that no written notification was given to either R20 or RR-A for either hospitalization. During an interview on 2/13/25 at 9:45 a.m. with the administrator an E. Interact or E. Transfer form should be faxed or given to the resident when transferred. For emergency department visits only bed holds are not issued. Discharged or transferred patients receive a verbal bed hold notification over the phone from resident representatives and the SSD followed up the next day with family. In R20's case due to payor source, the bed hold was null and void. The administrator and surveyor discussed the difference between bed hold and written transfers and the administrator verified that written notifications were not provided to R20's RR-A. During an interview on 2/13/25 at 9:58 a.m., RR-A verified that he never received a written transfer notice for either hospitalization. R6's quarterly Minimum Data Set (MDS) dated 12/26/24, indicated intact cognition and	21925			

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21925	Continued From page 23 diagnoses of central cord syndrome at C5 level of cervical spine, spinal stenosis, and spondylosis (cervical region). It further indicated R6 required substantial assistance with most activities of daily living (ADL) and mobility. During interview on 2/13/25 at 1:57 p.m., family member (FM)-B stated R6's had been to the hospital 4 times since admission and she had never been called regarding R6 being transferred to the hospital nor had she ever received anything in writing. FM-B also verified R6's most recent hospitalization was on 12/15/25. R6's progress notes dated 1/15/2025, at 5:57 p.m., indicated the following: -Transfer details: sent to North Memorial Health -Hospital date: 12/13/2024 19:20 -Sent From: Good Samaritan Society - Specialty Care Community Unit: BC -Reason(s) for Transfer: Hypertension (uncontrolled) -Contact notified of transfer and resident condition: [FM-B] -Contact type: -Emergency contact telephone: (813) 447-**** (cell). -Notified of Transfer? Yes. -Aware of clinical situation? Yes R6's progress note lacked documentation the transfer notice was provided in writing. The facility policy titled Sanford Policy Discharge and Transfer-Rehab/Skilled, Therapy & Rehab dated 1/9/25, indicated on page three, before a location transfers or discharges a resident, the location must: Notify the resident and the resident's representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand.	21925			

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21925	Continued From page 24 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21925			