



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 7, 2025

Administrator

Moose Lake Village

710 SOUTH KENWOOD AVENUE

Moose Lake, MN 55767

RE: CCN: 245491

Cycle Start Date: May 15, 2025

Dear Administrator:

On July 2, 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](mailto:sarah.lane@state.mn.us)





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
May 30, 2025

Administrator  
Moose Lake Village  
710 South Kenwood Avenue  
Moose Lake, MN 55767

RE: CCN: 245491  
Cycle Start Date: May 15, 2025

Dear Administrator:

On May 15, 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.



Moose Lake Village

May 30, 2025

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

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

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

## DEPARTMENT CONTACT

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

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

## 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 August 15, 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 November 15, 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](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>



Moose Lake Village

May 30, 2025

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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](mailto:travis.ahrens@state.mn.us)  
Web: [www.sfm.dps.mn.gov](http://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](mailto:sarah.lane@state.mn.us)



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

PRINTED: 06/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

|                                                               |                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                          |  |                                                                    |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245491</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>05/15/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOOSE LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>710 SOUTH KENWOOD AVENUE</b><br><b>MOOSE LAKE, MN 55767</b>                  |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| E 000                                                         | Initial Comments                                                                                                                                                                                                                                                                                                              | E 000                                                                      |                                                                                                                          |  |                                                                    |
|                                                               | On 5/12/25-5/15/25, 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 5/12/25-5/15/25, 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 with NO deficiencies cited:                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                          |  |                                                                    |
|                                                               | H54914291C MN105712<br>H54914309C MN112901                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                          |  |                                                                    |
|                                                               | The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. |                                                                            |                                                                                                                          |  |                                                                    |
|                                                               | Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.                                                                                                                                                  |                                                                            |                                                                                                                          |  |                                                                    |

|                                                                       |       |            |
|-----------------------------------------------------------------------|-------|------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE  |
| Electronically Signed                                                 |       | 06/09/2025 |

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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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOOSE LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>710 SOUTH KENWOOD AVENUE</b><br><b>MOOSE LAKE, MN 55767</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                        |
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| F 568<br>SS=D                                                 | <p>Accounting and Records of Personal Funds<br/>CFR(s): 483.10(f)(10)(iii)</p> <p>§483.10(f)(10)(iii) Accounting and Records.<br/>(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br/>(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br/>(C)The individual financial record must be available to the resident through quarterly statements and upon request.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and document review, the facility failed to provide a financial statement to 1 of 2 residents (R4) who had requested to receive a quarterly statement of their personal funds account.</p> <p>Findings include:</p> <p>R4's annual Minimum data Set (MDS) dated 4/11/25, identified R4 was cognitively intact.</p> <p>During an interview on 5/12/25 at 3:27 p.m., R4 stated she had a personal trust account but was not getting any statements. R4 stated she was not sure how much money she had in the account.</p> <p>During an interview on 5/14/25 at 1:46 p.m., business office manager (BOM)-F verified R4 had a personal trust account and identified the statements were going to her "old" home address. BOM-F verified R4 should have been</p> | F 568                                                                      | <p>F568 Plan of Correction<br/>It is the policy of Cassia to comply with the regulation requiring facilities to provide residents with a financial statement of their personal funds account upon request.<br/>To assure continued compliance, the following plan has been put into place:</p> <ul style="list-style-type: none"><li>• The following corrective action will be done for the resident(s) found to have been affected by the deficient practice:<br/>Resident R4 will be provided with the requested quarterly financial statement of their personal funds account immediately. Additionally, a meeting will be held with R4 to ensure they understand the process for requesting future statements.</li><li>• Actions taken to identify other potential residents having similar occurrences:<br/>An interview of all cognitive residents who do not already receive their statement or</li></ul> |  | 6/27/25                                                                |



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

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| F 568                                                         | Continued From page 2<br>receiving her statements.<br><br>During an interview on 5/14/25 at 2:12 p.m., the<br>administrator verified the facility should follow the<br>procedure in their policy.<br><br>During a phone interview on 5/14/25 at 2:27 p.m.,<br>the corporate associate vice president of revenue<br>cycle management verified R4's statement should<br>have been going to R4 and not to her former<br>home address.<br><br>The Trust fund policy and forms dated 11/15/24,<br>identified the resident or financially responsible<br>person would receive quarterly statements<br>detailing deposits, withdrawals and interest<br>earned. | F 568                                                                      | have a person identified as financially<br>responsible for them, will be conducted to<br>identify any other residents who may not<br>have received their statements and would<br>like to. <ul style="list-style-type: none"><li>Measures put in place to ensure<br/>deficient practice does not recur:<br/>The Business Office Manager will be<br/>retrained on the importance of timely<br/>processing of resident requests for<br/>financial statements. A log will be<br/>maintained to track all requests and<br/>ensure they are fulfilled within the required<br/>timeframe. Cognitive residents will be<br/>informed to make all resident trust fund<br/>requests to the Business Office.</li><li>Effective implementation of actions<br/>will be monitored by:<br/>The facility's Business Office Manager will<br/>audit 100% of resident financial statement<br/>requests monthly for three months to<br/>ensure compliance with providing<br/>statements upon request. Results of<br/>these audits will be reviewed by the facility<br/>QAPI committee, which will decide if<br/>further monitoring/audits are<br/>recommended.</li><li>The person responsible to maintain<br/>compliance is:<br/>Ashley Montague, Business Office<br/>Manager<br/>Shawna Smith, Administrator</li></ul> |  |                                                                        |
| F 657<br>SS=D                                                 | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must<br>be-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | F 657                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6/27/25                                                                |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOOSE LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>710 SOUTH KENWOOD AVENUE</b><br><b>MOOSE LAKE, MN 55767</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                        |
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| F 657                                                         | <p>Continued From page 3</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to identify and update the care plan with resident specific fall prevention interventions for 1 of 2 residents (R49) reviewed for multiple falls at the facility.</p> <p>Findings include:</p> <p>R49's admission Minimum Data Set (MDS) dated 4/3/25, indicated R49 was cognitively intact.</p> <p>R49's Resident Profile dated 5/15/25, included diagnoses of osteomyelitis, pain, chronic</p> | F 657                                                                      | <p>Plan of Correction for Deficiency F657</p> <p>It is the policy of Cassia (Facility name) to comply with the regulation cited under F657, which requires the facility to develop and implement a comprehensive person-centered care plan for each resident, including specific interventions for fall prevention.</p> <p>To assure continued compliance, the following plan has been put into place:</p> <p>The following corrective action will be done for the resident(s) found to have</p> |  |                                                                        |



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| F 657                                                         | <p>Continued From page 4</p> <p>respiratory failure, congestive heart failure, diabetes type II, repeated falls, muscle weakness, unsteadiness on feet, and unspecified abnormalities of gait and mobility.</p> <p>R49's Care plan dated 3/27/25 to 5/15/25, included the following:<br/>Resident needs assistance with ADL's, start date 3/27/25<br/>---Dressing: staff to provide assist of one for dressing.<br/>---Toileting: staff to provide assist of one with toileting.<br/>---Transfers:<br/>-----assist of 1 for transfers using a gait belt and hemi-walker (edited 4/7/25, from mod I)<br/>-----provide limited/extensive assist of one with walker for transfers. Cue before and after transfer (initiated 3/27/25)<br/>Falls, start date 3/27/25<br/>---follow toileting and repositioning schedule<br/>---gripper socks or non-skid footwear<br/>---monitor and assess if fall occurs, document circumstances/possible cause and notify MD and family<br/>---monitor for medication side effects<br/>---observe and meet resident needs<br/>---OT and PT to treat<br/>Behaviors, start date 3/27/25<br/>---resident does not exhibit adverse behavior symptoms</p> <p>R49's care plan showed the facility had changed R49's transfer assistance level to assist of one after R49's fall on 4/7/25. The care plan lacked evidence to show the facility had modified or implemented fall prevention interventions after review of 5 other falls that occurred at the facility between 4/2/25 and 5/8/25.</p> | F 657                                                                      | <p>been affected by the deficient practice:</p> <ul style="list-style-type: none"><li>• Resident R49 discharged on 5/22/2025.</li></ul> <p>Actions taken to identify other potential residents having similar occurrences:</p> <ul style="list-style-type: none"><li>• A facility-wide review will be conducted to identify any other residents who have experienced multiple falls. Each identified resident's care plan will be reviewed and updated as necessary to ensure specific fall prevention interventions are in place.</li><li>• All staff re-educated on 5/27/2025 that they must follow the residents care plan at all times and to notify the RN Nurse Manager, ADON or DON if they have questions regarding the care plan.</li></ul> <p>Measures put in place to ensure deficient practice does not recur:</p> <ul style="list-style-type: none"><li>• Staff will receive training on the importance of updating care plans with resident-specific interventions, particularly for fall prevention. Additionally, regular review and updating of care plans following any fall incident will occur at weekly Fall IDT meetings.</li></ul> <p>Effective implementation of actions will be monitored by:</p> <ul style="list-style-type: none"><li>• The DON or their designee will audit 25% of resident charts monthly for three months to ensure care plans include specific fall prevention interventions. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended.</li></ul> |  |                                                                        |



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| F 657                                                         | <p>Continued From page 5</p> <p>Event Reports for falls at the facility included:<br/>4/2/25 unwitnessed fall resident found on floor.<br/>Fall occurred in bathroom<br/>4/7/25 unwitnessed fall, resident found on floor in<br/>bathroom. Nursing note indicated R49 was sent<br/>to the emergency room to rule out shoulder<br/>dislocation/fracture. IDT review indicated R49 had<br/>fractured their clavicle bone and R49 was down<br/>graded from mod I in room per therapies.<br/>4/16/25 unwitnessed fall in resident room, Nurse<br/>note indicated R49 was found on floor in front of<br/>recliner. R49 indicated they had been attempting<br/>to pull pants up and lost their balance. Call light<br/>was on, R49 did not have slipper socks on.<br/>4/17/25: witnessed fall resident lowered to the<br/>floor Nursing Note: indicated resident was in<br/>recliner with feet resting on their wheelchair.<br/>Resident had slipped down between recliner and<br/>wheelchair and staff were not able to reposition<br/>resident back to chair, so resident was lowered to<br/>the floor.<br/>4/19/25: witnessed fall in resident room, resident<br/>lowered to floor with staff assistance during<br/>transfer<br/>5/8/25: unwitnessed fall in resident bathroom.<br/>Nurse note indicated R49's call light was ringing<br/>and R49 was found sitting on the floor between<br/>the toilet and their wheelchair. R49 stated they<br/>lost their balance and bumped their head. Small,<br/>raised area on crown noted.</p> <p>During an interview on 5/14/25 at 1:46 p.m., R49<br/>stated when they were in their room, they moved<br/>themselves between their wheelchair and bed,<br/>recliner and wheelchair and their wheel chair and<br/>toilet. However, if they had urgency to go, they<br/>called staff for help because when they rushed,<br/>they sometimes lost their balance. R49 stated</p> | F 657                                                                      | <p>The person responsible to maintain<br/>compliance is:</p> <ul style="list-style-type: none"><li>Ashley Bachman, DON</li></ul> |  |                                                                        |



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| F 657                                                         | <p>Continued From page 6</p> <p>they didn't think staff seemed to be concerned if they moved themselves from their chair to the wheelchair or if they went to the bathroom on their own.</p> <p>During an interview on 5/15/25 at 8:30 a.m., R49 stated they had therapy at 9:00 a.m., so they were going to get dressed and ready for therapy. R49 stated staff did not come in each morning and offer to assist her to the bathroom or with dressing, they got themselves to the bathroom and dressed on their own.</p> <p>During an interview on 5/15/25 at 8:33 a.m., nursing assistant (NA-A) stated R49 was independent with dressing and transfers. NA stated they got information on how residents transferred and dressed etc. during shift report from the off going shift.</p> <p>During an interview on 5/15/25 at 10:57 a.m., licensed practical nurse (LPN-A) stated if they noticed a resident was starting to transfer themselves, they would bring that forward to physical therapy (PT) and occupational therapy (OT) so they could re-evaluate the resident's transfer status and either advance them, or confirm they still needed assistance for transfers. R49 did try to transfer themselves on their own, because R49 wanted to be independent, however R49 knew they required assistance for transfers. Due to falls, R49 was moved closer to the nursing station. LPN-A stated when they went into R49's room, they educated R49 on calling for help for transfers and encouraged R49 to leave their door open for safety.</p> <p>During an interview on 5/15/25 at 12:38 p.m., the physical therapist assistant (PTA) stated R49 still</p> | F 657                                                                      |                                                                                                                          |  |                                                                        |



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| F 657                                                         | <p>Continued From page 7</p> <p>required stand by assist for transfers. R49 should not be transferring themselves alone. The PTA indicated they had tried ambulating R49 without their oxygen on, but R49's had not tolerated it well, their oxygen saturation had dropped. The PTA stated R49 had been on oxygen for years, and based on observation, the PTA felt R49 was very aware of the positioning of their oxygen tubing. The occupational therapist (OT) stated agreement with PTA, and said R49 was very aware of their oxygen tubing when they worked on transfers with R49. The OT also confirmed R49 should not transfer alone and explained R49 should also have standby to minimum assist with dressing and toileting.</p> <p>During an interview on 5/15/25 at 3:51 p.m., NA-B stated R49 did everything on their own and indicated if R40 needed help they would put their call light on, but otherwise R49 was doing everything by themselves for transfers and dressing.</p> <p>During an interview on 5/15/25 at 3:04 p.m. registered nurse (RN-A) stated all staff should know how a resident transfers. The transfer status is in the care plan and is also handed off at shift report. For short term rehabilitation residents if OT or PT updated a transfer status the change would get posted for staff to see and then it would also get updated in the care plan. Each resident fall is reviewed by the interdisciplinary team. The team reviews the fall and looks at what interventions can be implemented to prevent falls from happening again. Therapy may be involved too. After, the care plan should be updated, for instances if anti roll backs are added to the wheelchair, that would get updated on the care plan. RN-A indicated interventions didn't</p> | F 657                                                                      |                                                                                                                          |  |                                                                        |



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| F 657                                                         | <p>Continued From page 8</p> <p>necessarily have to go in the care plan. When reviewing R49's care plan, RN-A stated they had reviewed R49's care plan after each of R49's fall, but they hadn't marked it as reviewed. They normally just marked reviewed when changes were made to the care plan that staff needed to know about. For instance, R49 was moved closer to the desk after their fall on 4/16/25, but that was not put in the care plan. RN-A reviewed the EMR documentation for each of R49's six falls and confirmed R49 had had four unwitnessed falls related to self-transferring, three of which occurred in the bathroom, with one resulting in a collar bone fracture. RN-A stated they had changed R49's transfer status in the care plan from modified independence, to assist of one after the fall on 4/7/25. The IDT team had not identified any other fall prevention interventions to add to R49's care plan after they had reviewed each fall. There were other interventions not on the care plan. RN-A stated they could have added interventions to round on R49 more frequently and/or added interventions to address toileting needs to help prevent falls in the bathroom. RN-A indicated the IDT usually did look at bowel and bladder to see how the toileting schedule could be modified to prevent falls. It is possible our short-term staff may not know the transfer status of a resident but they should be checking the care plan. We need to have a process in place to make sure staff know when residents need transfer assistance.</p> <p>During an interview on 5/15/25 at 4:13 p.m., the director of nursing stated staff need to follow the care plan and indicated R49's care identified R49 required assistance for transfers. Each fall gets reviewed by the IDT team. The fall is discussed, possible contributing factors are identified and</p> | F 657                                                                      |                                                                                                                          |  |                                                                        |



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| F 657                                                         | <p>Continued From page 9</p> <p>reviewed, the resident and staff involved may be interviewed for additional information. We would then determine appropriate actions were taken or do further actions to prevent future falls. R49 prefers to be independent and does not accept help very well. As an intervention R49 was moved closer to the desk. R49's transfer status was modified on 4/7/25, after R49's fall that resulted in a broken collar bone. The DON confirmed no other modification or fall prevention interventions had been added to R49's care plan after subsequent falls. The DON reviewed R49's EMR fall documentation and stated the facility had done interventions, but they were not things that the DON would put in the care plan.</p> <p>During a follow-up interview at 5/15/25 at 4:49 p.m., the DON stated they had reviewed R49's care plan and indicated they did not feel any additional fall prevention interventions should have been added to R49's care plan, however R49's self-transfer behaviors should have been added to the care plan under behaviors.</p> <p>The facility policy Fall assessment and managing fall risk dated 11/6/23, included the following:<br/>--residents are assessed for fall upon admit, quarterly, with significant changes and as needed<br/>--fall risk and appropriate interventions to minimize the risk of falls/injury from falls are included in the care plan<br/>--each fall is investigated as soon as possible<br/>--based on fall review, interventions in the care plan are updated as indicated<br/>--interventions to reduce/prevent falls are reviewed with the resident and representative</p> <p>The facility policy Care plan and baseline care plan dated 10/14/25, included the following:</p> | F 657                                                                      |                                                                                                                          |  |                                                                        |



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| F 657                                                         | Continued From page 10<br>--the interdisciplinary team in conjunction with the resident and their support people will develop a comprehensive person-centered care plan for each resident<br>--the resident care plan is constantly changing. It is to be updated routinely to reflect the resident's current condition.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | F 657                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                        |
| F 689<br>SS=E                                                 | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure hot water temperatures were at safe temperatures at point-of-use for 27 of 27 residents who resided on the 200 hallway and the specialty care unit. In addition, the facility failed to ensure staff provided adequate supervision for transfers and activities of daily living for 2 of 2 residents (R49 and R40) and the facility further failed to follow the care plan related to transferring for the prevention of falls for 3 of 5 (R49, R40, R44) residents at risk for falls.<br><br>Findings include:<br><br>During a resident screening on 5/13/25 at 10:19 a.m., the hot water in bathroom of R34 felt very hot to touch after running the hot water for a | F 689                                                                      | F689 Plan of Correction<br>It is the policy of Cassia to comply with the regulation cited under F689.<br>To assure continued compliance, the following plan has been put into place:<br><br>The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: <ul style="list-style-type: none"><li>Blender valve necessary to maintain domestic hot water at safe levels for all 27 residents on the 200 hallway and the specialty care unit was not functioning properly and replaced on May 28, 2025.</li><li>Immediate reassessment and supervision provided for residents R49 and R40 during transfers and activities of daily living.</li></ul> |  | 6/27/25                                                                |



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| F 689                                                         | <p>Continued From page 11</p> <p>couple of minutes. R34 stated the water takes a while to get hot, but then it gets very hot, and she had to blend it with cold water to use it. R34 stated she and nursing assistants (NA)s had talked about it before.</p> <p>During an observation and interview on 5/14/25 at 2:17 p.m., maintenance worker (MW)-A, who identified as the director of maintenance, ran the hot water in R34's room and used a thermometer to measure the temperature at 134 degrees Fahrenheit (F). MW-A stated that was too hot and he felt 105 to 110 degrees F seemed to be a good spot for the hot water, but MW-A wasn't sure what the upper limit of the hot water should be.</p> <p>During an interview on 5/14/25 at 2:41 p.m., MW-A reported the blender valve that feeds the 200 hallway and specialty care unit was showing the temperature as 110 degrees, so it must not be working. At 2:50 p.m., room 209's hot water measured 129 degrees F; the dirty utility room across the hall from room 211 had hot water temperatures of 131 degrees F; the handwashing sink in the common area of the specialty care unit measured 127 degrees F. MW-A stated he had called a contractor to come take a look at it as soon as possible, and he turned down the blender valve 10 degrees F. At 3:10 p.m., the administrator stated all of the alert residents, and all of the staff had been updated on not using the tubs until they can consistently hold the temperatures below 120 degrees. MW-A stated he would continue to take the water temperature to ensure it got below 120 degrees.</p> <p>During an interview on 5/15/25 at 8:23 a.m., trained medication aid (TMA)-A stated she had</p> |                                                                            |  | F 689                                                                                                   | <ul style="list-style-type: none"><li>Care plans for residents R49, R40, and R44 have been reviewed to ensure proper transfer procedures are followed to prevent falls.</li></ul> <p>Actions taken to identify other potential residents having similar occurrences:</p> <ul style="list-style-type: none"><li>Conducted a facility-wide audit of hot water temperatures at all points-of-use on all shifts daily until blender valve was replaced.</li><li>Reviewed care plans and supervision protocols for residents who have had previous fall(s) or at high risk for falls according the their fall risk assessment, to ensure compliance with transfer procedures.</li></ul> <p>Measures put in place to ensure deficient practice does not recur:</p> <ul style="list-style-type: none"><li>Monthly audits of facility water temperatures are conducted per routine maintenance to ensure safe temperature levels. All staff educated to report any hot water concerns to maintenance immediately on May 14, 2025 and again on May 27, 2025. Residents educated at Resident Council to report any concerns related to water temperature immediately to staff on May 29, 2025.</li><li>All Staff training on 5/27/2025 regarding adherence to care plans for transfers and activities of daily living.</li><li>Nursing Staff will have a skill compliance check regarding reading resident care plans.</li><li>Nursing Staff will be re-educated to our policy indicating transfer/gait belt use is required.</li></ul> |                                                                        |                            |



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| F 689                                                         | <p>Continued From page 12</p> <p>started her shift at 3 a.m. this morning and had taken hot water temperatures in all the resident rooms and common areas and reported the temperatures were as low as 110 and up to 120 degrees F.</p> <p>A review of facility-submitted Monthly Water Temperature Chart for 2/7/25 revealed the following temperatures (recorded in degrees F):</p> <p>Room 204 was 128<br/>Room 215 was 130<br/>Room 402 was 126<br/>Room 408 was 126<br/>Room 200 was 126<br/>North nursing station sink was 130<br/>West nursing station sink was 130<br/>The kitchen sink in the specialty cares unit was 130</p> <p>A review of the facility-submitted Event Summary Reports from 5/13/24 to 5/14/25 revealed no burn incidents.</p> <p>During an interview on 5/15/25 at 4:13 p.m., the administrator stated hot water temperature was taken monthly and recorded on the Monthly Water Temperature Chart. This would be done by MW-A or he may have delegated to another maintenance worker, but MW-A should be the one who reviewed the temperatures. The administrator stated she wasn't aware there had been temperatures above 120 degrees F in the past months, and unless there was an issue she wouldn't necessarily look through the temperature logs. She would expect it to be brought to her attention if there were temperatures above 120 degrees F.</p> | F 689                                                                      | <p>Effective implementation of actions will be monitored by:</p> <ul style="list-style-type: none"><li>• The facility will audit water temperature once per week through July 2025 to ensure the blender valve is functioning properly and then resume monthly audits in August 2025. The facility will audit 50% of resident transfer and supervision records weekly for three months to ensure compliance with proper supervision. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended.</li><li>• The nursing team will be audited while performing cares and/or transfers for compliance with following the care plan and transfer/gait belt use as follows: 2 staff weekly through July 2025 and then 3 staff monthly for 2 additional months. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended.</li></ul> <p>The person responsible to maintain compliance is:</p> <ul style="list-style-type: none"><li>• James Golphenee, Maintenance Director or Designee</li><li>• Ashley Bachman, Director of Nursing</li></ul> |  |                                                                        |



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| F 689                                                         | <p>Continued From page 13</p> <p>During an interview on 5/15/25 at 4:33 p.m., MW-A confirmed he was responsible for taking hot water temperatures monthly, if there were an instance where he was gone the other maintenance worker would take them. MW-A stated he noticed the temperatures crept up a little bit in February, but it wasn't too extreme, and he speculated maybe they had been adjusting things. MW-A stated making sure the water wasn't too hot was important because it could mean hazards and burns. MW-A further stated he had continued to monitor the hot water temperatures, and they were coming in consistently under 120 degrees F and the new mixing valve had been ordered. He stated he would continue to monitor the temperatures until the valve was replaced.</p> <p>A policy, Preventative Maintenance Program SNF and AL dated 2/5/25, identified all Cassia sites shall have a standard preventative maintenance program that includes safety rounds, inspections and audits of all areas to maintain a safe, clean and well-maintained environment. This preventative maintenance program will also include a systematic method for reporting repairs and on-going mitigation of all safety risks. Maintenance tasks will be conducted as part of a systematic program to meet all local, state and federal regulations and additional Cassia standards of practice for building/grounds code compliance and general maintenance. The audit procedures didn't contain a line item for testing hot water.</p> <p>R49:</p> <p>R49's admission Minimum Data Set (MDS) dated 4/3/25, indicated R49 was cognitively intact.</p> |                                                                            |  | F 689                                                                                                   |                                                                                                                          |                                                                        |                            |



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| F 689                                                         | <p>Continued From page 14</p> <p>R49's Resident Profile dated 5/15/25, included diagnoses of osteomyelitis, pain, chronic respiratory failure, congestive heart failure, diabetes type II, repeated falls, muscle weakness, unsteadiness on feet, and unspecified abnormalities of gait and mobility.</p> <p>R49's Care plan dated 3/27/25 to 5/15/25, included the following:<br/>Resident needs assistance with ADL's, start date 3/27/25<br/>---Dressing: staff to provide assist of one for dressing.<br/>---Toileting: staff to provide assist of one with toileting.<br/>---Transfers:<br/>-----assist of 1 for transfers using a gait belt and hemi-walker (edited 4/7/25, from mod I)<br/>-----provide limited/extensive assist of one with walker for transfers. Cue before and after transfer (initiated 3/27/25)<br/>Falls, start date 3/27/25<br/>---follow toileting and repositioning schedule<br/>---gripper socks or non-skid footwear<br/>---monitor and assess if fall occurs, document circumstances/possible cause and notify MD and family<br/>---monitor for medication side effects<br/>---observe and meet resident needs<br/>---OT and PT to treat Behaviors, start date 3/27/25<br/>---resident does not exhibit adverse behavior symptoms</p> <p>R49's Event Reports for falls at the facility indicated R49 had sustained 6 falls at the facility between the dates of 4/2/25 and 5/8/25. noted.</p> | F 689                                                                      |                                                                                                                          |  |                                                                        |



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| F 689                                                         | <p>Continued From page 15</p> <p>During an interview on 5/14/25 at 1:46 p.m., R49 stated when they were in their room, they moved themselves between their wheelchair and bed, recliner and wheelchair and their wheelchair and toilet. However, if they had urgency to go, they called staff for help because when they rushed, they sometimes lost their balance. R49 stated they didn't think staff seemed to be concerned if they moved themselves from their chair to the wheelchair or if they went to the bathroom on their own.</p> <p>During an interview on 5/15/25 at 8:30 a.m., R49 stated they had therapy at 9:00 a.m., so they were going to get dressed and ready for therapy. R49 stated staff did not come in each morning and offer to assist her to the bathroom or with dressing, they got themselves to the bathroom and dressed on their own.</p> <p>During an interview on 5/15/25 at 8:33 a.m., nursing assistant (NA-A) stated R49 was independent with dressing and transfers. NA stated they got information on how residents transferred and dressed etc. during shift report from the off going shift.</p> <p>During an interview on 5/15/25 at 10:57 a.m., licensed practical nurse (LPN-A) stated if they noticed a resident was starting to transfer themselves, they would bring that forward to physical therapy (PT) and occupational therapy (OT) so they could re-evaluate the resident's transfer status and either advance them, or confirm they still needed assistance for transfers. R49 did try to transfer themselves on their own, because R49 wanted to be independent, however R49 knew they required assistance for transfers.</p> |                                                                            |  | F 689                                                                                                   |                                                                                                                          |                                                                        |                            |



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| F 689                                                         | <p>Continued From page 16</p> <p>Due to falls, R49 was moved closer to the nursing station. LPN-A stated when they went into R49's room, they educated R49 on calling for help for transfers and encouraged R49 to leave their door open for safety.</p> <p>During an interview on 5/15/25 at 12:38 p.m., the physical therapist assistant (PTA) stated R49 still require stand by assist for transfers. R49 should not be transferring themselves alone.</p> <p>The occupational therapist (OT) stated R49 should not transfer alone and explained R49 should also have standby to minimum assist with dressing and toileting.</p> <p>During an interview on 5/15/25 at 3:51 p.m., NA-B stated R49 did everything on their own and indicated if R40 needed help they would put their call light on, but otherwise R49 was doing everything by themselves for transfers and dressing.</p> <p>R40:</p> <p>R40's admission MDS dated 4/5/25, indicated R40 was cognitively intact.</p> <p>R40's Resident Profile dated 5/15/25, included diagnoses of unspecified fracture of upper end of right tibia, anemia, history of falling, repeated falls, weakness, unsteadiness on feet, and abnormalities in gait and mobility.</p> <p>R49's Care plan dated 3/29/25 to 5/15/25, included the following:<br/>Resident needs assistance with ADL's, start date 3/29/25<br/>---Resident to ambulate with therapy only<br/>--- Bed mobility: Assist of one</p> |                                                                            |  | F 689                                                                                                   |                                                                                                                          |                                                                        |                            |



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| F 689                                                         | <p>Continued From page 17</p> <p>---Eating: Resident does require assist with setup</p> <p>---Grooming: staff to provide 1 assist with grooming.</p> <p>---Oral care: staff to provide 1 assist with oral care</p> <p>---Dressing: staff to provide assist of one for dressing.</p> <p>---Toileting: staff to provide assist of one with toileting.</p> <p>---Transfers: Cue resident before/during, assist of 1 stand pivot using gait belt grab bars and w/c arm rest.</p> <p>Falls, start date 3/29/25</p> <p>---follow toileting and repositioning schedule</p> <p>---gripper socks or non-skid footwear</p> <p>---monitor and assess if fall occurs, document circumstances/possible cause and notify MD and family</p> <p>---monitor for medication side effects</p> <p>---observe and meet resident needs</p> <p>---OT and PT to treat</p> <p>Behaviors, start date 3/29/25</p> <p>---resident does not exhibit adverse behavior symptoms</p> <p>During an interview on 5/12/25 at 3:39 p.m., R40 was wheeling self out of bathroom and indicated they had just finished using the restroom. R40 pointed to the transfer belt on the counter and stated therapy staff used the transfer belt but only one out of ten staff used it when they helped with transfers. R40 stated they had not had a fall at the facility and indicated they transferred themselves in the bathroom even though they had been told to call for help.</p> <p>During an interview on 5/15/25 at 8:33 a.m., NA-A stated R40 was independent with dressing and transfers. NA stated they got information on how</p> | F 689                                                                      |                                                                                                                          |  |                                                                        |



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| F 689                                                         | <p>Continued From page 18</p> <p>residents transferred and dressed etc. during shift report from the off going shift.</p> <p>During an interview on 5/15/25 9:24 a.m., R40 stated they had washed and dressed themselves this morning, staff did not come in and help with getting dressed. R40 stated they had transferred themselves this morning.</p> <p>During an interview on 5/15/25 at 10:36 a.m., NA-C confirmed they were working on the transitional care unit (TCU). NA-C explained the residents on the TCU typically needed less assistance. NA-C stated they hadn't had to assist R40 with anything this a.m. They were not sure if R40 needed assistance with transfers/cares, but they could find that information in R40's care plan if they needed it.</p> <p>During an interview on 5/15/25 at 10:57 a.m., licensed practical nurse LPN-A stated R40 was an assist of one for transfers. R40 called when they needed assistance for transfers.</p> <p>During an interview on 5/15/25 at 12:38 p.m., with PTA and OT, PTA stated R40 had not been approved for self-transfers yet. The OT stated R40 required stand by assist with dressing.</p> <p>During an interview on 5/15/25 at 3:51 p.m., NA-B stated R40 needed partial assistance with stand pivot transfers but could dress self. NA-B stated they always used a transfer belt when they transferred residents.</p> <p>During an interview on 5/15/25 at 3:04 p.m., registered nurse (RN-A) stated R49 and R40 were not independent with transfers and could call for assistance. RN-A indicated all staff should</p> | F 689                                                                      |                                                                                                                          |  |                                                                        |



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| F 689                                                         | <p>Continued From page 19</p> <p>know how a resident transferred. The transfer status was in the care plan and also got handed off at shift report. For TCU residents if OT or PT updated a transfer status the change would get posted for staff to see and then it would also get updated in the care plan. It is possible our short-term staff may not know the transfer status of a resident; they should be checking and following the care plan. We need to have a process in place to make sure staff know when residents need transfer assistance.</p> <p>During an interview on 5/15/25 at 4:13 p.m., the director of nursing (DON) stated R49 and R40 were not independent with transfers, and indicated they expected staff to follow the care plan for patient transfer status and activities of daily living.</p> <p>The facility policy Fall assessment and managing fall risk dated 11/6/23, included the following:<br/>--residents are assessed for fall upon admit, quarterly, with significant changes and as needed<br/>--fall risk and appropriate interventions to minimize the risk of falls/injury from falls are included in the care plan<br/>--based on fall review, interventions in the care plan are updated as indicated<br/>--interventions to reduce/prevent falls are reviewed with the resident and representative</p> <p>The facility policy Care plan and baseline care plan dated 10/14/25, included the following:<br/>--the interdisciplinary team in conjunction with the resident and their support people will develop a comprehensive person-centered care plan for each resident<br/>--the resident care plan is constantly changing. It is to be updated routinely to reflect the resident's</p> | F 689                                                                      |                                                                                                                          |  |                                                                        |



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| F 689                                                         | <p>Continued From page 20<br/>current condition</p> <p>R44:</p> <p>R44's quarterly Minimum Data Set (MDS) dated 1/28/25, identified R44 was cognitively intact and had no behaviors or refusals of care. In addition, R44's MDS identified R44 had a diagnosis of paraplegia (a condition characterized by paralysis of the lower body typically the legs), schizophrenia, and neurogenic bladder (condition that causes loss of bladder control due to nerve, spinal cord, or brain issue).</p> <p>R44's Care area assessment (CAA) dated 8/11/24, identified R44 had the following risk factors for falls: psychotropic medication use, cognitive impairment related to schizophrenia, bowel incontinence, and presence of a foley catheter.</p> <p>R44's care plan dated 2/6/23, identified R44 required assistance with transfers and ambulation due to falls risk. Interventions included an assist of one staff for pivot transfers with a gait belt.</p> <p>R44's fall risk assessment dated 4/25/25, identified R44 was a moderate risk for falls "related to toxic encephalopathy, cramp and spasms, pain, use of antipsychotic and antidepressant medications, Foley catheter." Last fall was 11/24/24.</p> <p>During an observation on 5/14/25 at 7:02 a.m., nursing assistant (NA)-D assisted R44 to the side of the bed, brought the wheel chair close to the bed locked the brakes on the wheel chair assisted R44 to stand, pulled up his pants and transferred R44 to the wheel chair. The gait belt</p> |                                                                            |  | F 689                                                                                                   |                                                                                                                          |                                                                        |                            |



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| F 689                                                         | Continued From page 21<br><br>was on the bedside table but was not used during the transfer.<br><br>During an interview on 5/14/25 at 7:23 a.m., NA-D stated interventions for transfer did not include a transfer belt only needed to have him stand and pivot and needed to remind him to "stand tall".<br><br>During an interview on 5/15/25 at 10:30 a.m., licensed practical nurse (LPN)-A verified R44 could be transferred with the assist of one staff and a transfer belt needed to be used.<br><br>During an interview on 5/15/25 at 11:05 a.m., the director of nursing (DON) verified staff should follow the care plan and use a transfer belt for safety with transfers as identified in care plans.<br><br>Fall assessment and managing fall risk dated 11/6/23, identified "Transfer/gait belt use is required during any transfer or ambulation where the resident needs stand by or higher level of assistance during transfers or ambulation." | F 689                                                                      |                                                                                                                          |  |                                                                        |
| F 699<br>SS=D                                                 | Trauma Informed Care<br>CFR(s): 483.25(m)<br><br>§483.25(m) Trauma-informed care<br>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the                                                                                                                                                                                                                                                                                                                                                                                                                                               | F 699                                                                      | F699 Plan of Correction                                                                                                  |  | 6/27/25                                                                |



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| F 699                                                         | <p>Continued From page 22</p> <p>facility failed to assess post-traumatic stress disorder (PTSD) symptoms and triggers and carry them forward to the care plan for 1 of 1 resident (R19) reviewed for trauma informed care.</p> <p>Findings include:</p> <p>R19's admission Minimum Data Set (MDS) dated 2/17/25, identified intact cognition and diagnoses of anxiety, major depressive disorder, psychotic disorder, PTSD, frontotemporal neurocognitive disorder, severe dementia with agitation, delusional disorder, and paranoid delusions. The MDS also identified R19 had hallucinations, delusions, verbal behavior toward others, and had behavior which significantly disrupted the living environment.</p> <p>R19's care plan dated 2/11/25, identified a problem statement for trauma-informed care related to a history of trauma of physical abuse as a minor from alcoholic parents including being tied up by the arms and legs to a bed, having socks placed in her mouth due to screaming, and was burned with cigarettes. The goal for R19 was for care provided to mitigate the risk of re-traumatization. The intervention on 2/11/25 was that R19 was fine with both male and female caregivers. Other problem statements related to behavior, psychotropic medication use, and mood state did not contain triggers or symptoms for PTSD.</p> <p>R19's electronic medical record (EMR) didn't contain an assessment of PTSD symptoms or triggers.</p> <p>During an interview on 5/15/25 at 9:49 a.m.,</p> |                                                                            |  | F 699                                                                                                   | <p>It is the policy of Cassia to comply with the regulation cited under F699, which pertains to the assessment and care planning for residents with post-traumatic stress disorder (PTSD) symptoms and triggers.</p> <p>To assure continued compliance, the following plan has been put into place: The following corrective action will be done for the resident(s) found to have been affected by the deficient practice:<br/>*A Trauma Informed care plan was completed on 2/11/2025 with the information known at the time of admission. Nursing management and Social Services responsible for writing the care plans were made aware of a new trigger, the closing of the door by staff, on 5/15/2025. Care Plan was updated with the new information and the updated care plan with this new trigger was communicated to nursing staff.</p> <p>Actions taken to identify other potential residents having similar occurrences:<br/>*A review of all current residents' records will be conducted to identify any other individuals who may have PTSD symptoms or triggers that have not been adequately assessed or included in their care plans. These Trauma Informed care plans will be reviewed at care conferences and as needed.</p> <p>Measures put in place to ensure deficient practice does not recur:<br/>*Staff will receive training on identifying and assessing PTSD symptoms and</p> |                                                                        |                            |



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| F 699                                                         | <p>Continued From page 23</p> <p>social services designee (SSD)-A stated the facility didn't have a specific assessment for PTSD, it was screened for when a person was admitted by reading their history and diagnoses. SSD-A added she also would ask the resident on admission if there was anyone they didn't want to contact them, or if they had had any trauma. R19's daughter had talked with SSD-A about R19's history of abuse and learned one thing not to do would be to make her feel confined, so something she wouldn't like would be when you closed a door on her. SSD-A reviewed R19's care plan and confirmed this wasn't an intervention on her care plan, nor did the care plan indicate what may trigger her PTSD, and that would be helpful to put on there. SSD-A stated she had verbally talked with the staff about not closing doors on her.</p> <p>During an interview on 5/15/25 at 10:21 a.m., nursing assistant (NA)-E confirmed she worked in the specialty care unit and was familiar with R19. She stated approach was important for R19, and she would tell you who she liked and didn't like, and that you can't try to correct her. NA-E stated she was aware of R19's PTSD diagnosis, but wasn't aware of triggers, just knew she was abused by her parents. NA-E stated she would look in the care plan or ask social services if she had questions.</p> <p>During an interview on 5/15/25 at 10:25 a.m., trained medication aid (TMA)-A confirmed she worked in the specialty care unit and was familiar with R19. TMA-A stated she was aware of R19's PTSD, and knew R19 can't feel trapped. TMA-A provided an example where R19 wheeled her wheelchair backwards into a corner of the hallway and started to "freak out" because she thought</p> |                                                                            |  | F 699                                                                                                   | <p>triggers, and the importance of incorporating these into individualized care plans.</p> <ul style="list-style-type: none"><li>• All Staff training on 5/27/2025 regarding their responsibility to the adherence to care plans.</li><li>• Nursing Staff will have a skill compliance check regarding reading resident care plans.</li><li>• Effective implementation of actions will be monitored by:<br/>The facility will audit 25% of resident charts monthly for three months to ensure PTSD symptoms and triggers are assessed and included in care plans. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended.</li></ul> <p>The person responsible to maintain compliance is:</p> <ul style="list-style-type: none"><li>• Ashley Bachman, Director of Nursing</li></ul> |                                                                        |                            |



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| F 699                                                         | Continued From page 24<br><br>she was stuck. TMA-A added it was important for staff not to close her bedroom door, R19 herself could close it, but staff could not. TMA-A stated she knew these things about R19 from word of mouth.<br><br>During an interview on 5/15/25 at 3:57 p.m., the director of nursing (DON) stated they didn't have a PTSD assessment, but they did do a psychosocial history where abuse was asked about. The DON stated R19's PTSD interventions fell under psychotropic medications and/or mood and behavior on the care plan because it got complicated.<br><br>A policy, Trauma Informed Care dated 11/15/24, identified as part of the admission comprehensive assessment the facility will identify history of trauma or interpersonal violence when possible, using the social history and psycho-social observation tool. If a resident shares a history of trauma, a trauma-informed care plan will be developed with appropriate information to help guide staff in an effort to avoid re-traumatization. | F 699                                                                      |                                                                                                                          |  |                                                                        |
| F 757<br>SS=E                                                 | Drug Regimen is Free from Unnecessary Drugs<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | F 757                                                                      |                                                                                                                          |  | 6/27/25                                                                |



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| F 757                                                         | <p>Continued From page 25</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure medication orders for residents contained an indication for the medication for 3 of 5 (R19, R37, R49) residents reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R19:</p> <p>R19's admission Minimum Data Set (MDS) dated 2/17/25, identified intact cognition and diagnoses of frontotemporal neurocognitive disorder (a type of dementia), severe dementia with agitation, delusional disorders, paranoid delusions, hypothyroidism, asthma, restless leg syndrome, urinary incontinence, post-traumatic stress disorder (PTSD), major depressive disorder, weakness, and fatigue. R19's MDS also identified hallucinations, delusions, verbal behavior toward others, and behavior significantly disrupts the living environment.</p> <p>R19's care plan last reviewed 5/13/25, didn't identify diagnoses or problem statements for hypertension, constipation, fluid retention, or</p> | F 757                                                                      | <p>F757 Plan of Correction</p> <p>It is the policy of Cassia to comply with the regulation cited under F757, which requires that medication orders for residents contain an indication for the medication.</p> <p>To assure continued compliance, the following plan has been put into place:</p> <p>The following corrective action will be done for the resident(s) found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"><li>For residents R19, R37, and R49, the facility will immediately review and update their medication orders to include the indication for each medication prescribed.</li></ul> <p>Actions taken to identify other potential residents having similar occurrences:</p> <ul style="list-style-type: none"><li>A comprehensive review of all current residents' medication orders will be conducted to ensure that each order includes an indication for the medication.</li></ul> <p>Measures put in place to ensure deficient practice does not recur:</p> |  |                                                                        |



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| F 757                                                         | <p>Continued From page 26</p> <p>issues with the skin in the perineal area.</p> <p>R19's provider orders identified the following medications without indications:</p> <p>-2/11/25 Miralax (a powder medication used to treat constipation) 17 grams daily as-needed (PRN) daily</p> <p>-2/11/25 furosemide (a medication that helps rid the body of excess fluid) 40 mg daily</p> <p>-2/11/25 hydrocortisone cream (topical corticosteroid used to treat mild inflammatory skin conditions) 2.5% perineal application with non-pharmacologic interventions to wash and dry affected area thoroughly, warm bath, and lotion area two times a day PRN</p> <p>-2/12/25 Magnesium oxide (a mineral used to treat a variety of conditions from constipation to low blood levels of magnesium) tablet 400 mg give orally before morning meal</p> <p>-4/1/25 docusate (a stool softener) 200 mg daily</p> <p>-4/1/25 Senna S (a stool softener plus a stimulant laxative) daily PRN</p> <p>-4/7/25 lisinopril (a medication used primarily to treat hypertension) 5 mg daily</p> <p>R37:</p> <p>R37's quarterly MDS dated 4/9/25, identified severely impaired cognition and diagnoses of left-sided hemiplegia and hemiparesis after a cerebral vascular accident (CVA, or stroke), dysphagia (difficulty swallowing), diabetes mellitus, long-term use of insulin, major depressive disorder, hypertension, gastroesophageal reflux disorder (GERD), hyperlipidemia (high cholesterol), low back pain, urinary incontinence, thrombocytopenia (abnormally low number of platelets in the blood),</p> | F 757                                                                      | <ul style="list-style-type: none"><li>Staff will receive training on the importance of including medication indications in orders. Additionally, the Health Information Manager will audit all new medication orders daily via a report from facility's EHR to verify that indications are documented.</li></ul> <p>Effective implementation of actions will be monitored by:</p> <ul style="list-style-type: none"><li>The facility will audit 25% of medication charts weekly for three months to ensure that all medication orders include an indication. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended.</li></ul> <p>The person responsible to maintain compliance is:</p> <ul style="list-style-type: none"><li>Ashley Bachman, DON</li></ul> |  |                                                                        |



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| F 757                                                         | <p>Continued From page 27</p> <p>hearing loss, and dementia with psychotic disturbance.</p> <p>R37's care plan dated 4/8/25, didn't identify diagnoses or problem statements for sleep disturbance or nausea.</p> <p>R37's provider orders identified the following medications without indications:</p> <p>-11/7/23, melatonin (a hormone that regulates sleep-wake cycle) 6 mg at bedtime</p> <p>-2/7/25, ondansetron (medication used to treat nausea) 4 mg every six hours PRN</p> <p>During an interview on 5/15/25 at 1:40 p.m., the assistant director of nursing (ADON) stated they had recognized there weren't diagnoses with the medications, and found the issue was that every time an order changed the diagnosis wasn't being carried forward with the medication. The ADON stated they had implemented education with their health unit coordinators (HUC)s, and with the providers so that moving forward the medications would have indications. The ADON stated it was important to have the indication, so they knew they were giving the right medication.</p> <p>A policy, Transcription of Orders dated 2/12/24, identified all resident orders would be transcribed per policy and procedure. Item number six of the policy indicated per regulations and practice standards all medication orders must include the name of medication, dosage, route, and frequency. Each medication must also include a diagnosis for usage. Under item 8b, the policy indicated the nurse who verified the order would review order documentation and ensure the full transcription of orders had been completed and</p> |                                                                            |  | F 757                                                                                                   |                                                                                                                          |                                                                    |                            |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOOSE LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>710 SOUTH KENWOOD AVENUE</b><br><b>MOOSE LAKE, MN 55767</b>                                                                                                                                                                                                                                                                                                                      |                            |                                                                        |
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| F 757                                                         | Continued From page 28                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | F 757                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                                                                        |
| F 812<br>SS=D                                                 | <p>was accurate and updated EHR via acknowledgment order is verified.</p> <p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.<br/>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br/>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br/>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br/>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on observation and interview the facility failed to utilize beard coverings in the kitchen to ensure sanitary conditions were maintained in food preparation areas. This deficient practice had the potential to impact all residents who received nourishment from the facility dietary services.</p> <p>Findings include:</p> <p>During an observation on 5/12/25 at 1:26 p.m., the food service consultant (FSC-A) was in the</p> | F 812                                                                      | <p>F812 Plan of Correction<br/>It is the policy of Cassia to comply with the regulation cited under F812, which requires the utilization of beard coverings in the kitchen to ensure sanitary conditions are maintained in food preparation areas.</p> <p>To assure continued compliance, the following plan has been put into place:<br/>The following corrective action will be done for the resident(s) found to have</p> | 6/27/25                    |                                                                        |



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

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOOSE LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>710 SOUTH KENWOOD AVENUE</b><br><b>MOOSE LAKE, MN 55767</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                        |
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| F 812                                                         | <p>Continued From page 29</p> <p>main kitchen area without a beard covering. FSC-A provided a tour of the kitchen food prep area, food dry and cold storage areas, the dishwashing area, and dish storage area while not wearing a beard covering.</p> <p>During an observation on 5/14/25 at 8:00 a.m., the culinary director (CD) was located behind the cook's prep table and did not have a beard covering on.</p> <p>During a continuous observation on 5/14/25 at 10:42 a.m. to 11:46 a.m., both the CD and FSC-A did not wear a beard covering during the following observed events:</p> <p>--10:43 a.m. to 1048 a.m., FSC-A stood in front of the cook's prep area without a beard covering as cook (C-A) pulled food from the oven and temped it.</p> <p>--10:51 a.m., dietary aide DA-A entered the kitchen without placing a beard covering over their beard. DA-A remained in the kitchen and wrapped silverware in napkins without a beard covering.</p> <p>--10:57 a.m. to 11:10 a.m., FSC-A remained in front of cook's area without a beard covering.</p> <p>--10:59 a.m., DA-A was still wrapping silverware without beard covering on.</p> <p>--11:17 a.m., CD walked behind the prep area between C-A and the oven without a beard covering and returned with a plastic bin. C-A put chicken in the bin and CD removed the bin from the cook's work area.</p> <p>--11:23 a.m. the CD sanitized hands, applied gloves and removed a utensil from the cook's prep table and brought it over to where C-A was pureeing food.</p> <p>--11:24 a.m., FSC-A was at a workstation without a beard cover on placing dessert bars into lidded</p> | F 812                                                                      | <p>been affected by the deficient practice: All kitchen staff were immediately provided with beard coverings, and those involved in food preparation were instructed to wear them at all times while in the kitchen.</p> <p>Actions taken to identify other potential residents having similar occurrences:<br/>*A review of all kitchen staff was conducted to ensure that all individuals with facial hair are equipped with and using beard coverings during food preparation.</p> <p>Measures put in place to ensure deficient practice does not recur:<br/>*All staff education was conducted on 5/27/2025 regarding the requirement and the importance of using beard coverings.</p> <p>Effective implementation of actions will be monitored by:<br/>The kitchen supervisor will audit 100% of kitchen staff during each shift for three months to ensure compliance with beard covering usage. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended.</p> <p>The person responsible to maintain compliance is:<br/>*Jay Pittman, Director of Nutritional Services</p> |  |                                                                        |



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| F 812                                                         | <p>Continued From page 30</p> <p>serving containers.</p> <p>--11:40 a.m., DA-A, CD, and FSC-A remained in the kitchen area without beard coverings.</p> <p>--11:41 a.m. CD removed chicken from the oven and temped the chicken and returned the chicken to the oven.</p> <p>--11:46 a.m., FSC-A removed chicken from the oven and temped it (no beard covering).</p> <p>During an observation on 5/15/25 at 10:00 a.m., the CD was in the kitchen without a beard covering standing at the cook prep table with C-B.</p> <p>During an interview on 5/14/25 at 12:01 p.m., the CD and FSC-A stated culinary staff get education on safe food preparation and handling, hand washing, infection prevention, and they also complete other required facility and food service topics. In addition, staff get training and coaching on the job.</p> <p>During an observation on 5/15/25 at 9:15 a.m., the CD was in the cook's area of the kitchen without a beard covering.</p> <p>During a follow-up interview on 5/15/25 at 12:14 a.m., the CD confirmed staff had not been wearing required beard coverings in the kitchen areas between 5/12/25 and 5/15/25. The CD explained they had just had mandatory mask wearing lifted and they had not implemented the switch back to wearing beard coverings. The CD stated beard coverings were required in the kitchen for sanitary and infection prevention reasons. The CD indicated beard coverings had been ordered and placed at the entrances to the kitchen and were to be worn by any staff with a beard who entered the kitchen area.</p> |                                                                            |  | F 812                                                                                                   |                                                                                                                          |                                                                        |                            |



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| K 000                                                         | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/14/2025. At the time of this survey, Moose Lake Village was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. |                                                                            |  | K 000                                                                                             |                                                                                                                          |                                                        |                            |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE  |
| Electronically Signed                                                 |       | 06/09/2025 |

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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| K 000                                                         | <p>Continued From page 1</p> <p>Healthcare Fire Inspections<br/>State Fire Marshal Division<br/>445 Minnesota St., Suite 145<br/>St. Paul, MN 55101-5145, OR</p> <p>By email to:<br/>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH<br/>DEFICIENCY MUST INCLUDE ALL OF THE<br/>FOLLOWING INFORMATION:</p> <p>1. A detailed description of the corrective action<br/>taken or planned to correct the deficiency.</p> <p>2. Address the measures that will be put in<br/>place to ensure the deficiency does not reoccur.</p> <p>3. Indicate how the facility plans to monitor<br/>future performance to ensure solutions are<br/>sustained.</p> <p>4. Identify who is responsible for the corrective<br/>actions and monitoring of compliance.</p> <p>5. The actual or proposed date for completion of<br/>the remedy.</p> <p>Moose Lake Village was inspected as one<br/>building. and is a 1-story building with small<br/>partial basement. The original building was<br/>constructed in 1964 and additions constructed in<br/>1968 and 1977, all of Type II(111 construction). A<br/>single story hospital adjoins the nursing home<br/>and is separated by a 4 hour wall. To the south a<br/>single story type V(111) assisted living facility also<br/>adjoins and is separated by 4 hour construction<br/>with a 3 hour rated, self closing door. Therefore,<br/>the nursing home was inspected as one building.</p> |                                                                            |  | K 000                                                                                             |                                                                                                                          |                                                        |                            |



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|                                                               | The facility has a capacity of 60 beds and had a<br>census of 49 at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |  |                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                 |                                                        |                            |
| K 223<br>SS=D                                                 | The requirements at 42 CFR, Subpart 483.70(a),<br>are NOT MET as evidenced by:<br>Doors with Self-Closing Devices<br>CFR(s): NFPA 101<br><br>Doors with Self-Closing Devices<br>Doors in an exit passageway, stairway enclosure,<br>or horizontal exit, smoke barrier, or hazardous<br>area enclosure are self-closing and kept in the<br>closed position, unless held open by a release<br>device complying with 7.2.1.8.2 that automatically<br>closes all such doors throughout the smoke<br>compartment or entire facility upon activation of:<br>* Required manual fire alarm system; and<br>* Local smoke detectors designed to detect<br>smoke passing through the opening or a required<br>smoke detection system; and<br>* Automatic sprinkler system, if installed; and<br>* Loss of power.<br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation and staff interview, the<br>facility failed to install self-closing device per<br>NFPA 101 (2012 edition), Life Safety Code,<br>section 19.3.2.1.3 and 19.3.2.1.5. These deficient<br>findings could have an isolated impact on the<br>residents within the facility.<br><br>Findings include:<br><br>On 05/14/2025 at 11:30am, it was revealed by<br>observation that the lower level storage room |                                                                            |  | K 223                                                                                             |                                                                                                                                                                                                                                                                                                                                                                 |                                                        | 6/27/25                    |
|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |  |                                                                                                   | K223<br>Brief description of corrective action or<br>planned corrective action:<br>The facility will not prevent doors with<br>self-closing devices from operating<br>properly per NFPA 101 (2012 edition), Life<br>Safety Code, sections 19.3.2.1.3 and<br>19.3.2.1.5 to ensure compliance and<br>enhance resident safety.<br><br>Steps to prevent recurrence: |                                                        |                            |



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

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245491</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/14/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOOSE LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>710 SOUTH KENWOOD AVENUE<br/>MOOSE LAKE, MN 55767</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                        |                            |
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| K 223                                                         | Continued From page 3<br>276, that is equipped with a self closing device<br>was being held open with one gallon jug of hand<br>sanitizer at the time of inspection.<br><br>An interview with the Maintenance Director and<br>Regional Director of Operations verified these<br>deficient finding at the time of discovery.                                                                                                                                                                                   |                                                                            |  | K 223                                                                                             | *All doors with a self-closing device within<br>the facility were audited for items that<br>would prevent proper closure of the door.<br>*All staff were re-educated of this<br>requirement on June 6, 2025 and<br>re-education will be conducted again in<br>July 2025.<br><br>How the facility plans to monitor future<br>performance to ensure solutions are<br>sustained:<br>*All doors will be audited for items<br>preventing the doors to close properly<br>weekly through July 2025 and then<br>ongoing inspections will be added to our<br>routine Safety Audits conducted by the<br>Safety Committee and findings will be<br>corrected immediately and reported at the<br>quarterly Safety Committee for<br>appropriate follow up.<br><br>Person responsible for compliance:<br>*James Golphene, EVS Director or<br>designee |                                                        | 6/27/25                    |
| K 291<br>SS=E                                                 | Emergency Lighting<br>CFR(s): NFPA 101<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration<br>is provided automatically in accordance with 7.9.<br>18.2.9.1, 19.2.9.1<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation the facility failed to<br>maintain emergency lighting system per NFPA<br>101 (2012 edition), Life Safety Code sections<br>19.2.9.1 and 7.9.1.3. This deficient practice could<br>have a patterned impact on the residents within |                                                                            |  | K 291                                                                                             | K291<br>Brief description of corrective action or<br>planned corrective action:<br>*The facility had annual inspection reports<br>documented 1/16/2025 and also had a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                        |                            |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOOSE LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>710 SOUTH KENWOOD AVENUE<br/>MOOSE LAKE, MN 55767</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                        |
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| K 291                                                         | Continued From page 4<br>the facility.<br><br>Findings include:<br><br>On 05/14/2025 at 10:12am, it was revealed by<br>observation that the facility failed to conduct the<br>annual 90 minute required Emergency Lighting<br>test.<br><br>An interview with the Maintenance Director,<br>Facility Administrator and Regional Director of<br>Operations verified these deficient finding at the<br>time of discovery. | K 291                                                                      | vendor under contract begin doing the<br>annual inspection of Emergency lighting<br>on 2/12/2025, which we did not have<br>documentation of at the time of the<br>survey. The documentation reviewed by<br>the Fire Marshal at time of survey was<br>noted to be incomplete regarding the<br>follow up done when a problem was noted<br>during the inspection per NFPA 101 (2012<br>edition), Life Safety Code sections<br>19.2.9.1 and 7.9.1.3. Environmental<br>Service Director educated and confirms<br>understanding of this requirement and will<br>document any follow up to the reports and<br>make available for review.<br><br>Steps to prevent recurrence:<br>*Vendor has us flagged for annual<br>inspection of Emergency Lighting for<br>February of each year. Environmental<br>Service Director has added to the Routine<br>Maintenance a reminder of the service<br>one month in advance so he can confirm<br>annual visit with vendor.<br><br>How the facility plans to monitor future<br>performance to ensure solutions are<br>sustained:<br>*Annual Documentation of required<br>annual inspection will be reviewed<br>quarterly with Administrator or designee to<br>ensure compliance with requirement of<br>NFPA standards.<br><br>Person responsible for compliance:<br>*James Golphene, Director of<br>Environmental Services |  |                                                        |
| K 345<br>SS=F                                                 | Fire Alarm System - Testing and Maintenance                                                                                                                                                                                                                                                                                                                                                                           | K 345                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 6/27/25                                                |



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| K 345                                                         | <p>Continued From page 5<br/>CFR(s): NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance<br/>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br/>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 10.12.4, 14.3.1, 14.4.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>1. On 05/14/2025 at 09:17am, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Director that the facility could not provide current documentation verifying that a semiannual inspection of initiating devices had been completed.</p> <p>2. On 05/14/2025 at 09:17am, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Services Director that the facility could not provide an annual fire alarm testing documentation that provided a complete listing of</p> |                                                                            |  | K 345                                                                                             | <p>K345<br/>Brief description of corrective action or planned corrective action:<br/>*On 5/27/2025, the facility engaged a certified fire alarm technician to conduct the annual inspection of the fire alarm system to ensure compliance with NFPA 101 (2012 edition) and NFPA 72 (2010 edition) standards. Any repairs needed as a result of the inspection are being addressed and will be documented.<br/>*A semiannual inspection of initiating devices will be done 6 months after the Annual Inspection was completed or before 11/27/2025.<br/>*The Annual Inspection on 5/27/2025 included the required sensitivity testing. Documentation of Annual Testing, including the sensitivity testing, is available upon request.</p> <p>Steps to prevent recurrence:<br/>*Scheduled inspections and maintenance of the fire alarm system by a certified technician by vendor one year from May 27, 2025. Reminder of this requirement</p> |                                                        |                            |



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| K 345                                                         | Continued From page 6<br><br>each individual device tested, to include device<br>type, address, location and the test results for<br>each individual device.<br><br>Based on a review of available documentation<br>and staff interview, the facility failed to maintain<br>the fire alarm system per NFPA 101 (2012<br>edition), Life Safety Code, section 9.6.1.3, and<br>NFPA 72 (2010 edition), National Fire Alarm and<br>Signaling Code section 14.2.1.2.2. These<br>deficient findings could have a patterned impact<br>on the residents within the facility.<br><br>Findings include:<br><br>On 05/14/2025 at 09:17am, it was revealed by a<br>review of available documentation that the last<br>annual fire alarm inspection report that the facility<br>could not provide documentation that a sensitivity<br>testing had been conducted within the last two (2)<br>years.<br><br>An interview with the Maintenance Director,<br>Facility Administrator and Regional Director of<br>Operations verified these deficient finding at the<br>time of discovery. | K 345                                                                      | also scheduled in Facility's routine<br>maintenance program.<br><br>How the facility plans to monitor future<br>performance to ensure solutions are<br>sustained:<br>*Conduct quarterly audits of the fire alarm<br>system logbook to ensure all inspections<br>and maintenance activities are<br>documented and up-to-date.<br><br>Person responsible for compliance:<br>*James Golphennee, Director of<br>Environmental Services |  |                                                        |
| K 353<br>SS=F                                                 | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are<br>inspected, tested, and maintained in accordance<br>with NFPA 25, Standard for the Inspection,<br>Testing, and Maintaining of Water-based Fire<br>Protection Systems. Records of system design,<br>maintenance, inspection and testing are<br>maintained in a secure location and readily<br>available.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | K 353                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6/27/25                                                |



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| K 353                                                         | <p>Continued From page 7</p> <p>a) Date sprinkler system last checked<br/>_____</p> <p>b) Who provided system test<br/>_____</p> <p>c) Water system supply source<br/>_____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br/>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 05/14/2025 at 10:10am, it was revealed by a review of available documentation the facility failed to perform the annual and quarterly sprinkler system testing.</p> <p>Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9.</p> |                                                                            |  | K 353                                                                                             | <p>K353<br/>Brief description of corrective action or planned corrective action:<br/>*The facility engaged a certified fire protection service to complete the annual inspection and service the automatic sprinkler system on 5/15/2025 to ensure compliance with NFPA 101 (2012 edition) and NFPA 25 (2011 edition) standards.</p> <p>Steps to prevent recurrence:<br/>*Quarterly inspections and maintenance of the sprinkler system by a certified fire protection service are scheduled for no later than 8/15/2025 by the vendor and a reminder has been added to the Facility's routine maintenance system.<br/>*Annual inspection and maintenance of the sprinkler system by a certified fire protection service is scheduled for no later than 5/15/2026 by the vendor and a reminder has been added to the Facility's routine maintenance system.<br/>*Storage materials found to be within 18 inches under the sprinkler heads were lowered or removed so that facility would be in compliance with this standard.</p> |                                                        |                            |



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| K 353                                                         | Continued From page 8<br>These deficient findings could a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/14/2025 at 11:28am, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in:<br><br>1) Medical Records room 283<br>2) Mothers Room on lower level<br>3) Room 275 on lower level<br>4) Room 280 on lower level<br><br>An interview with the Maintenance Director and Regional Director of Operations verified these deficient finding at the time of discovery. | K 353                                                                      | *All staff educated 5/27/2025 on the storage requirement of items being at least 18 inches below a sprinkler head.<br><br>How the facility plans to monitor future performance to ensure solutions are sustained:<br>*The facility will conduct quarterly audits of the sprinkler system maintenance documentation and review inspection reports to ensure compliance. Any discrepancies will be addressed immediately, and findings will be reported in the quarterly safety committee meetings and the quarterly QAPI meetings.<br>*A visual audit of storage rooms and other areas of the facility with sprinkler heads will be conducted weekly though July 2025 and then monthly for 2 months after. Any discrepancies will be addressed immediately, and findings will be reported in the quarterly safety committee meetings and the quarterly QAPI meetings.<br><br>Person responsible for compliance:<br>*James Golphenees, Director of Environmental Services |                            |                                                        |
| K 372<br>SS=F                                                 | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall.                                                                                                                                                                                                                                                                                                                                                                                 | K 372                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6/27/25                    |                                                        |



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| K 372                                                         | <p>Continued From page 9</p> <p>Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 05/14/2025 between 10:46am and 11:38am, it was revealed by observation that there is penetrations running from one smoke compartment to another in the fire walls and/or smoke barrier walls in the following locations:</p> <p>1) penetration above Fire Door 361<br/>2) two (2) penetrations North Nurses Station<br/>3) penetration above Fire Door 74<br/>4) penetration above Fire Door 53<br/>5) penetration above Fire Door 68</p> <p>An interview with the Maintenance Director and Regional Director of Operations verified these deficient finding at the time of discovery.</p> |                                                                            |  | K 372                                                                                             | <p>K372</p> <p>Brief description of corrective action or planned corrective action:</p> <p>*The facility will immediately repair and seal all identified penetrations in the smoke barrier to ensure compliance with NFPA 101 (2012 edition) standards. This includes using appropriate fire-resistant materials to restore the integrity of the smoke barrier.</p> <p>Steps to prevent recurrence:</p> <p>*Conduct a comprehensive inspection of all smoke barriers within the facility to identify any additional penetrations or deficiencies.</p> <p>*Implement a routine maintenance schedule to regularly inspect and maintain smoke barriers.</p> <p>*Train maintenance staff on the importance of maintaining smoke barriers and the correct methods for repairing any penetrations.</p> <p>How the facility plans to monitor future performance to ensure solutions are sustained:</p> <p>*The facility will perform quarterly audits of all smoke barriers to ensure they remain</p> |                                                        |                            |



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| K 372                                                         | Continued From page 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | K 372                                                                      | intact and compliant with NFPA 101 standards.<br>*Results of these audits will be addressed promptly and reviewed at the quarterly safety committee meetings and quarterly QAPI Committee meetings for any further action.                                                                                                                                                                                                                                                                                                   |                            |                                                        |
| K 521<br>SS=F                                                 | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by:<br>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, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include: | K 521                                                                      | Person responsible for compliance:<br>*James Golphenee, Director of Environmental Services<br><br><br><br><br><br><br><br><br><br>K521<br>Brief description of corrective action or planned corrective action:<br>*The facility has contracted with a vendor for an immediate inspection of all fire dampers to ensure compliance with NFPA 101 (2012 edition) and NFPA 105 (2010 edition) standards. A certified fire safety contractor will conduct these inspections, pending confirmation from vendor, by June 27, 2025. | 6/27/25                    |                                                        |



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| K 521                                                         | Continued From page 11<br><br>On 05/14/2025 at 10:45am, it was revealed by a review of available documentation that the facility could not provide a 4-year fire damper inspection report.<br><br>An interview with the Maintenance Director, Facility Administrator and Regional Director of Operations verified these deficient finding at the time of discovery.                                                                                                                          | K 521                                                                      | Steps to prevent recurrence:<br>*Environmental Services Director and Administrator will meet at least quarterly to review documentation of requirement ensuring inspections occur at least every four years as required.<br>*Train maintenance staff on the importance of fire damper inspections and the potential impact on resident safety.<br><br>How the facility plans to monitor future performance to ensure solutions are sustained:<br>*The facility will conduct quarterly audits of the fire damper inspection logs to ensure compliance with the established schedule. Any discrepancies will be addressed immediately, and findings will be reported to the safety committee and QAPI committee for any further action needed.<br><br>Person responsible for compliance:<br>*James Golphennee, Environmental Services Director |  |                                                        |
| K 712<br>SS=F                                                 | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>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 | K 712                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 6/27/25                                                |



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| K 712                                                         | <p>Continued From page 12</p> <p>alarms.<br/>19.7.1.4 through 19.7.1.7<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 05/14/2025 at 09:05am, it was revealed by a review of available documentation that fire drills were not completed: second shift missing second quarter (Apr-Jun) and third shift, third quarter (July - September) drills completely.</p> <p>An interview with the Maintenance Director, Facility Administrator and Regional Director of Operations verified these deficient finding at the time of discovery.</p> | K 712                                                                      | <p>K712<br/>Brief description of corrective action or planned corrective action:<br/>*The facility will immediately conduct fire drills at varied times and under different conditions to comply with NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1.</p> <p>Steps to prevent recurrence:<br/>*Drills are scheduled at random times, including nights and weekends, to ensure varied conditions.<br/>*Document each drill with details on time, conditions, and staff participation.<br/>*Environmental Services Director and Administrator will meet monthly to review the Fire Drill Documentation and ensure compliance with drills.</p> <p>How the facility plans to monitor future performance to ensure solutions are sustained:<br/>*Monthly audits of fire drill logs will be conducted to verify compliance with varied times and conditions.<br/>*Logs will be reviewed at the quarterly safety committee meeting to ensure compliance with the monthly drills and make any necessary adjustments. Will also be reviewed quarterly at QAPI for any further action.</p> <p>Person responsible for compliance:<br/>*James Golphenee, Director of</p> |  |                                                        |



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| K 712                                                         | Continued From page 13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | K 712                                                                      | Environmental Services                                                                                                   |  | 6/27/25                                                |
| K 781<br>SS=E                                                 | Portable Space Heaters<br>CFR(s): NFPA 101<br><br>Portable Space Heaters<br>Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to implement its portable space heater policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8. These deficient findings could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/14/2025 at 11:21am, it was revealed by observation of portable space heaters in Nurses Office in contradiction on the site policy. That states "space heaters are prohibited".<br><br>On 05/14/2025 at 11:21am, it was revealed by observation of portable space heaters in Human Resources Office in contradiction on the site policy. That states "space heaters are prohibited", this space heater was also plugged into a power-strip which is also in violation of K920.<br><br>An interview with the Maintenance Director and Regional Director of Operations verified these deficient finding at the time of discovery. |                                                                            |                                                                                                                          |  |                                                        |



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| K 781                                                         | Continued From page 14                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | K 781                                                                      | the quarterly safety committee meetings<br>and quarterly QAPI meetings to ensure<br>ongoing compliance.                  |  |                                                        |
| K 918<br>SS=F                                                 | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System<br>Maintenance and Testing<br>The generator or other alternate power source<br>and associated equipment is capable of supplying<br>service within 10 seconds. If the 10-second<br>criterion is not met during the monthly test, a<br>process shall be provided to annually confirm this<br>capability for the life safety and critical branches.<br>Maintenance and testing of the generator and<br>transfer switches are performed in accordance<br>with NFPA 110.<br>Generator sets are inspected weekly, exercised<br>under load 30 minutes 12 times a year in 20-40<br>day intervals, and exercised once every 36<br>months for 4 continuous hours. Scheduled test<br>under load conditions include a complete<br>simulated cold start and automatic or manual<br>transfer of all EES loads, and are conducted by<br>competent personnel. Maintenance and testing of<br>stored energy power sources (Type 3 EES) are in<br>accordance with NFPA 111. Main and feeder<br>circuit breakers are inspected annually, and a<br>program for periodically exercising the<br>components is established according to<br>manufacturer requirements. Written records of<br>maintenance and testing are maintained and<br>readily available. EES electrical panels and<br>circuits are marked, readily identifiable, and | K 918                                                                      | Person responsible for compliance:<br>*James Golphenee, Environmental<br>Services Director                               |  | 6/27/25                                                |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOOSE LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>710 SOUTH KENWOOD AVENUE<br/>MOOSE LAKE, MN 55767</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                        |                            |
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| K 918                                                         | <p>Continued From page 15</p> <p>separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 05/14/2025 at 10:30am, it was revealed by a review of available documentation of the emergency generator maintenance and testing that an annual generator inspection was not performed.</p> <p>An interview with the Maintenance Director, Facility Administrator and Regional Director of Operations verified these deficient finding at the time of discovery.</p> |                                                                            |  | K 918                                                                                             | <p>K918</p> <p>Brief description of corrective action or planned corrective action:</p> <p>*The facility did have a certified technician to inspect and service the generators to ensure compliance with NFPA 99 (2012 edition) and NFPA 110 (2010 edition) standards on 12/12/2024, however, facility was unable to present the documentation at time of survey. The documentation is now available and the generators are now fully operational and compliant.</p> <p>Steps to prevent recurrence:</p> <p>*Annual maintenance checks by certified technicians are scheduled by vendor each year and the next annual inspection is due no later that 12/12/2024.</p> <p>How the facility plans to monitor future performance to ensure solutions are sustained:</p> <p>*The Environmental Services Director and Administrator will meet quarterly to ensure required inspections and the supporting documentation are in place to ensure ongoing compliance with NFPA standards.</p> <p>Person responsible for compliance:</p> <p>*James Golphene, Environmental Services Director</p> |                                                        |                            |



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

PRINTED: 06/11/2025  
FORM APPROVED  
OMB NO. 0938-0391

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MOOSE LAKE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>710 SOUTH KENWOOD AVENUE<br/>MOOSE LAKE, MN 55767</b>                                                                                                                                                                                                                                                                                                           |                            |                                                        |
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| K 920<br>SS=D                                                 | <p>Electrical Equipment - Power Cords and Extens<br/>CFR(s): NFPA 101</p> <p>Electrical Equipment - Power Cords and<br/>Extension Cords<br/>Power strips in a patient care vicinity are only<br/>used for components of movable<br/>patient-care-related electrical equipment<br/>(PCREE) assemblies that have been assembled<br/>by qualified personnel and meet the conditions of<br/>10.2.3.6. Power strips in the patient care vicinity<br/>may not be used for non-PCREE (e.g., personal<br/>electronics), except in long-term care resident<br/>rooms that do not use PCREE. Power strips for<br/>PCREE meet UL 1363A or UL 60601-1. Power<br/>strips for non-PCREE in the patient care rooms<br/>(outside of vicinity) meet UL 1363. In non-patient<br/>care rooms, power strips meet other UL<br/>standards. All power strips are used with general<br/>precautions. Extension cords are not used as a<br/>substitute for fixed wiring of a structure.<br/>Extension cords used temporarily are removed<br/>immediately upon completion of the purpose for<br/>which it was installed and meets the conditions of<br/>10.2.4.<br/>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8<br/>(NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br/>This REQUIREMENT is not met as evidenced<br/>by:<br/>Based on observation and staff interview, the<br/>facility failed to maintain the usage of electrical<br/>adaptive devices per NFPA 99 (2012 edition),<br/>Health Care Facilities Code, sections 10.5.2.3.1<br/>and 10.2.4.2.1, NFPA 70, (2011 edition), National<br/>Electrical Code, sections 400-8, and UL 1363.<br/>This deficient finding could have an isolated<br/>impact on the residents within the facility.</p> <p>Findings include:</p> | K 920                                                                      | <p>K920<br/>Brief description of corrective action or<br/>planned corrective action:<br/>*The facility immediately discontinued the<br/>use of non-compliant electrical adaptive<br/>devices and replaced them with devices<br/>that meet NFPA 99 (2012 edition), NFPA<br/>70 (2011 edition), and UL 1363 standards.</p> <p>Steps to prevent recurrence:<br/>*Conduct a facility-wide audit to identify</p> | 6/27/25                    |                                                        |



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| K 920                                                         | <p>Continued From page 17</p> <p>On 05/14/2025 at 12:53pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas;</p> <p>1) Refrigerator plugged into multi-plug adapter in Activities Office<br/>2) Heat press in laundry was plugged into power-strip<br/>3) Space Heater plugged into power-strip in Human Resources Office</p> <p>An interview with the Maintenance Director and Regional Director of Operations verified these deficient finding at the time of discovery.</p> | K 920                                                                      | <p>and remove any non-compliant electrical adaptive devices.<br/>*All staff education done on 5/27/2025 prohibiting the use of power strips, multi-plug adapters and/or extension cords unless they have been approved for use by the Environmental Services Director.</p> <p>How the facility plans to monitor future performance to ensure solutions are sustained:<br/>*The Safety Committee will conduct quarterly inspections for use of power strips, multi-plug adapters and/or extension cords for immediate notification to the Environmental Services Director who will confirm that their use is in compliance with NFPA and UL standards. Results will be reviewed in quarterly safety meetings and quarterly QAPI meetings to determine if further action is needed.</p> <p>Person responsible for compliance:<br/>*James Golphenee, Environmental Services Director</p> |                            |                                                        |