DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 4, 2025

Administrator
Heartwood
503 HEARTWOOD DRIVE
CROSBY, MN 56441

RE: CCN: 245332
Cycle Start Date: August 20, 2025

Dear Administrator:

On August 20, 2025, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 31, 2025

Administrator
Heartwood

503 HEARTWOOD DRIVE
CROSBY, MN 56441

RE: CCN:245232
Cycle Start Date: July 23, 2025

Dear Administrator:

On July 23, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

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

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 23, 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 January 23, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 7/21/25 through 7/23/25, 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.	E0000		07/31/2025
F0000	INITIAL COMMENTS On 7/21/25 through 7/23/25, 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: H52329769C (1064376), H52329768C (1064377, H52329767C (1064378), no deficiencies were issued 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 that substantial compliance with the regulations has been attained.	F0000		07/31/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F0641	Heartwood Care Center is dedicated to maintaining precision throughout the Resident Assessment Instrument (RAI) process, including the accurate coding of the Minimum Data Set (MDS). By maintaining meticulous standards in assessment accuracy, care planning, and interdisciplinary collaboration, we ensure that each resident receives individualized attention tailored to both their medical and psychosocial needs.	08/15/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0641 SS = D	Continued from page 1 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medications section of the Minimum Data Set (MDS) was accurately coded for 1 of 5 resident (R6) reviewed for unnecessary medications. Findings include: R6's admission Minimum Data Set (MDS) dated 4/28/25, identified R6 had intact cognition and included a diagnosis of type 2 diabetes. R12 received an injection of insulin one day per week. R6's Order Summary Report dated 6/30/25, identified semaglutide (a GLP-1 receptor agonist used primarily for managing type 2 diabetes and aiding in weight loss, with significant effects on appetite regulation and blood sugar control.) subcutaneous solution	F0641	Continued from page 1 Heartwood's policy for Resident Assessment Instrument (RAI) Process:3.0, Care Area Assessment and Care Planning Submission was reviewed by the Clinical Administrator on August 1, 2025, and remains appropriate. Admission MDS for R6 dated April 28, 2025, was modified by the Presbyterian Homes and Services (PHS) MDS Nurse on July 24, 2025. The modification included removal of the inaccurate coding of Semaglutide under N0350 as insulin. There are currently no other residents at Heartwood Care Center receiving Semaglutide or other GLP-1 receptor agonists. An audit will be conducted of all current residents the week of August 7, 2025, to verify that all residents coded on question N0350A (insulin injections in the last 7 days or since admission/reentry if less than 7 days) were coded correctly. Any discrepancies will be noted, and modification(s) will be made to correct the MDS. Education and clarification will be provided to the PHS MDS Nurses supporting Heartwood on August 7, 2025, by the RAI Director for the coding of Insulin Injections on the MDS. Audits will be conducted by the RAI Director, or designee, to ensure that accurate coding of this question on the MDS is completed for 4 weeks. If compliance is maintained, audits will be changed to monthly, pending review and recommendation by the facility's QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0641 SS = D	Continued from page 2 pen-injector 2 milligram (MG)/3 milliliter (ML) inject 0.5 mg subcutaneously one time a day every Monday for type 2 diabetes. An email from the coding department director dated 7/23/25 at 1216: p.m., identified R6's semaglutide was coded as insulin in error. During an interview on 7/23/25 at 12:37 a.m., the director of nursing (DON) stated MDS assessments should be coded correctly to ensure correct payment was received and to ensure the residents received the care they required. The facility policy Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning and Submission revised 3/25, identified the facility would complete the RAI in accordance with the utilization guideline set forth in the current MDS 3.0 RAI User's Manual. Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2024, identified the steps for assessment included: 1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Determine if the resident received insulin injections during the look-back period. 3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period. 4. Count the number of days insulin injections were received and/or insulin orders changed.	F0641		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care 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. This REQUIREMENT is NOT MET as evidenced by:	F0699	Heartwood Care Center is dedicated to providing culturally sensitive, trauma-informed care to residents with a history of trauma. This approach is grounded in recognized clinical standards and tailored to honor each individual's background and preferences, with the goal of minimizing risk and preventing re-traumatization. Heartwood's Trauma-Informed Care policy was reviewed by the Interdisciplinary Team (IDT) on August 4, 2025, and determined to remain appropriate.	08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0699 SS = D	Continued from page 3 Based on interview and document review, the facility failed to comprehensively assess for trauma informed care and identify potential triggers, to avoid potential re-traumatization for 1 of 1 resident (R6) reviewed for trauma informed care. Findings include: R6’s admission Minimum Data Set (MDS) dated 4/28/25, identified R6 had intact cognition and included a diagnosis of post traumatic stress disorder (PTSD). R6's medical record failed to identify a Trauma-Informed Care Assessment was completed. R6’s care plan revised 5/9/25, did not include R6’s PTSD triggers and/or interventions specific to his PTSD. During an interview on 7/21/25 at 2:22 p.m., R6 was lying in bed in her room. R6 spoke with a flat affect and stated she liked to keep to herself in her room. R6 stated she was unaware of any traumatic events in her life and could not recall anything that would make her upset specifically. During an interview on 7/23/25 at 9:05 a.m., registered nurse (RN)-B and nursing assistant (NA)-C stated they were both unaware of R6’s PTSD diagnosis. RN-B stated she heard R6 had had a “rough” childhood but didn't know any details. Neither were aware of any triggers for R6, but NA-C stated R6 was very withdrawn. Staff did offer activities and opportunities for R6 to get out of her room but R6 never wanted to. R6 did not like her blinds open until later in the day when R6 up and moving around. When R6’s family called R6, R6 was very quiet afterwards but R6 never told why. Neither could say if there was anything that made R6 uncomfortable or anything that should be avoided. During an interview on 7/23/25 at 10:08 a.m., RN-A stated social services was responsible to complete the Trauma Informed Care Assessment and would make care plan revisions if the assessment identified a problem. RN-A stated R6 was very stoic and had never told RN-A anything about any traumatic life events. R6 knew she was on medications but could not explain to you why she was on those medications. It would be important for staff to know those things because staff wanted to keep R6 comfortable and feeling secure and safe. During an interview on 7/23/25 at 12:37 p.m., the director of nursing (DON) stated R6 was admitted at the	F0699	Continued from page 3 As of May 6, 2025, Trauma-Informed Care assessments have been incorporated into the facility's newly implemented LTC Psychosocial Assessment. The updated assessment tool was subsequently reviewed by the IDT to support education and ensure understanding of its requirements. R6 was assessed on July 28, 2025, by the Director of Life Enrichment for trauma-informed care using the facility's LTC Psychosocial Assessment. R6s comprehensive care plan was updated to reflect assessment findings for trauma-informed care to support the resident's diagnosis of PTSD. On August 4-6, 2025, the Interdisciplinary Team (IDT) conducted a comprehensive review of all current resident records to verify completion of trauma-informed care assessments. For residents identified with a history of post-traumatic events, individualized care plans were reviewed and/or developed to address and support their specific trauma-related needs. Trauma-informed care education will be reviewed during the nursing team meeting scheduled for August 13, 2025. The session will include an overview of the assessment process used to identify residents at risk for post-traumatic stress disorder (PTSD) and the development of care planning goals aimed at mitigating or reducing exposure to trauma-related triggers. Weekly audits will be performed for all newly admitted residents over a four-week period to verify completion of trauma-informed care assessments and care planning. If compliance is consistently upheld, the audit schedule will transition to a monthly frequency, pending further review and recommendations by the facility's QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0699 SS = D	Continued from page 4 time the facility was changing ownership and electronic medical records. Because of this, R6 was “missed”, and a trauma informed care assessment was not completed. The DON stated the assessment should have been completed for staff to identify and care plan triggers and interventions for R6’s psychosocial needs. The facility Trauma Informed Care Policy revised 12/22, identified the facility would ensure staff assessed a resident who displayed or was diagnosed with mental disorder or psychological adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder and facilitate appropriate treatment and services to manage the assessed problem to attain the highest practicable mental and psychological well-being. The intent of this requirement was to ensure that the facility delivered care and services which, in addition to meeting professional standards, were delivered using approaches which were culturally competent and account for experiences and preferences and addressed the needs of trauma survivors by minimizing triggers and/or re-traumatization.	F0699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 23, 2025. At the time of this survey, Heartland Care Center 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 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:	K0000		07/31/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	Continued from page 1 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Cuyuna Regional Medical Center- Heartland is a 1-story building with no basement built in 2024 and was determined to be of Type V (111) construction. Facility is connected by a link that has proper separation to the Assisted Living. The facility is fully protected with an automatic sprinkler system and also has a fire alarm system which includes corridor smoke detection throughout and in all common areas that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0226 SS = E	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the Horizontal Exit per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.7 (3). This deficient finding could have a patterned impact on the residents within the facility.	K0226	The delayed egress doors located in the Pine and Aspen neighborhoods are currently difficult to open, representing a deficiency related to K-tag K0226. Rasinski Total Door Service (RTDS) was contacted by the Enviromental Services Director and scheduled to assess and troubleshoot the door issue during the week of August 4, 2025 (the earliest available date). RTDS identified the problem with the doors. Based on the findings, corrective action to fix the doors is scheduled to be completed on August 14, 2025, by RTDS to restore the doors to full compliance. These doors are subject to documented weekly inspections. Each inspection verifies functionality and records whether the doors meet required standards.	08/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0226 SS = E	Continued from page 2 Findings include: On 07/23/2025 at 10:30 AM, it was revealed by observation the horizontal exits in Aspen and Pine were difficult to open due to the amount of force needing to be used to open the door when tested. An interview with Environmental Services Director verified this deficient finding at the time of discovery.	K0226	Continued from page 2 The Enviromental Services Director will provide training to the maintenance personnel on the 15-pund maximum force requirement for operating delayed egress doors, as stipulated by code. Following completion of repairs, maintenance staff will incorporate force testing into the ongoing weekly inspection protocol to ensure continued compliance. The Environmental Services Director, in collaboration with RTDS, will oversee all remediation efforts to ensure corrective measures are implemented effectively and in accordance with applicable life safety standards by August 21, 2025.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 31, 2025

Administrator
Heartwood

503 HEARTWOOD DRIVE
CROSBY, MN 56441

RE: CCN:245232
Cycle Start Date: July 23, 2025

Dear Administrator:

On July 23, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

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

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 23, 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 January 23, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 7/21/25 through 7/23/25, 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.	E0000		07/31/2025
F0000	INITIAL COMMENTS On 7/21/25 through 7/23/25, 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: H52329769C (1064376), H52329768C (1064377, H52329767C (1064378), no deficiencies were issued 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 that substantial compliance with the regulations has been attained.	F0000		07/31/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F0641	Heartwood Care Center is dedicated to maintaining precision throughout the Resident Assessment Instrument (RAI) process, including the accurate coding of the Minimum Data Set (MDS). By maintaining meticulous standards in assessment accuracy, care planning, and interdisciplinary collaboration, we ensure that each resident receives individualized attention tailored to both their medical and psychosocial needs.	08/15/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0641 SS = D	Continued from page 1 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medications section of the Minimum Data Set (MDS) was accurately coded for 1 of 5 resident (R6) reviewed for unnecessary medications. Findings include: R6's admission Minimum Data Set (MDS) dated 4/28/25, identified R6 had intact cognition and included a diagnosis of type 2 diabetes. R12 received an injection of insulin one day per week. R6's Order Summary Report dated 6/30/25, identified semaglutide (a GLP-1 receptor agonist used primarily for managing type 2 diabetes and aiding in weight loss, with significant effects on appetite regulation and blood sugar control.) subcutaneous solution	F0641	Continued from page 1 Heartwood's policy for Resident Assessment Instrument (RAI) Process:3.0, Care Area Assessment and Care Planning Submission was reviewed by the Clinical Administrator on August 1, 2025, and remains appropriate. Admission MDS for R6 dated April 28, 2025, was modified by the Presbyterian Homes and Services (PHS) MDS Nurse on July 24, 2025. The modification included removal of the inaccurate coding of Semaglutide under N0350 as insulin. There are currently no other residents at Heartwood Care Center receiving Semaglutide or other GLP-1 receptor agonists. An audit will be conducted of all current residents the week of August 7, 2025, to verify that all residents coded on question N0350A (insulin injections in the last 7 days or since admission/reentry if less than 7 days) were coded correctly. Any discrepancies will be noted, and modification(s) will be made to correct the MDS. Education and clarification will be provided to the PHS MDS Nurses supporting Heartwood on August 7, 2025, by the RAI Director for the coding of Insulin Injections on the MDS. Audits will be conducted by the RAI Director, or designee, to ensure that accurate coding of this question on the MDS is completed for 4 weeks. If compliance is maintained, audits will be changed to monthly, pending review and recommendation by the facility's QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0641 SS = D	Continued from page 2 pen-injector 2 milligram (MG)/3 milliliter (ML) inject 0.5 mg subcutaneously one time a day every Monday for type 2 diabetes. An email from the coding department director dated 7/23/25 at 1216: p.m., identified R6's semaglutide was coded as insulin in error. During an interview on 7/23/25 at 12:37 a.m., the director of nursing (DON) stated MDS assessments should be coded correctly to ensure correct payment was received and to ensure the residents received the care they required. The facility policy Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning and Submission revised 3/25, identified the facility would complete the RAI in accordance with the utilization guideline set forth in the current MDS 3.0 RAI User's Manual. Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2024, identified the steps for assessment included: 1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Determine if the resident received insulin injections during the look-back period. 3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period. 4. Count the number of days insulin injections were received and/or insulin orders changed.	F0641		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care 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. This REQUIREMENT is NOT MET as evidenced by:	F0699	Heartwood Care Center is dedicated to providing culturally sensitive, trauma-informed care to residents with a history of trauma. This approach is grounded in recognized clinical standards and tailored to honor each individual's background and preferences, with the goal of minimizing risk and preventing re-traumatization. Heartwood's Trauma-Informed Care policy was reviewed by the Interdisciplinary Team (IDT) on August 4, 2025, and determined to remain appropriate.	08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0699 SS = D	Continued from page 3 Based on interview and document review, the facility failed to comprehensively assess for trauma informed care and identify potential triggers, to avoid potential re-traumatization for 1 of 1 resident (R6) reviewed for trauma informed care. Findings include: R6’s admission Minimum Data Set (MDS) dated 4/28/25, identified R6 had intact cognition and included a diagnosis of post traumatic stress disorder (PTSD). R6's medical record failed to identify a Trauma-Informed Care Assessment was completed. R6’s care plan revised 5/9/25, did not include R6’s PTSD triggers and/or interventions specific to his PTSD. During an interview on 7/21/25 at 2:22 p.m., R6 was lying in bed in her room. R6 spoke with a flat affect and stated she liked to keep to herself in her room. R6 stated she was unaware of any traumatic events in her life and could not recall anything that would make her upset specifically. During an interview on 7/23/25 at 9:05 a.m., registered nurse (RN)-B and nursing assistant (NA)-C stated they were both unaware of R6’s PTSD diagnosis. RN-B stated she heard R6 had had a “rough” childhood but didn't know any details. Neither were aware of any triggers for R6, but NA-C stated R6 was very withdrawn. Staff did offer activities and opportunities for R6 to get out of her room but R6 never wanted to. R6 did not like her blinds open until later in the day when R6 up and moving around. When R6’s family called R6, R6 was very quiet afterwards but R6 never told why. Neither could say if there was anything that made R6 uncomfortable or anything that should be avoided. During an interview on 7/23/25 at 10:08 a.m., RN-A stated social services was responsible to complete the Trauma Informed Care Assessment and would make care plan revisions if the assessment identified a problem. RN-A stated R6 was very stoic and had never told RN-A anything about any traumatic life events. R6 knew she was on medications but could not explain to you why she was on those medications. It would be important for staff to know those things because staff wanted to keep R6 comfortable and feeling secure and safe. During an interview on 7/23/25 at 12:37 p.m., the director of nursing (DON) stated R6 was admitted at the	F0699	Continued from page 3 As of May 6, 2025, Trauma-Informed Care assessments have been incorporated into the facility's newly implemented LTC Psychosocial Assessment. The updated assessment tool was subsequently reviewed by the IDT to support education and ensure understanding of its requirements. R6 was assessed on July 28, 2025, by the Director of Life Enrichment for trauma-informed care using the facility's LTC Psychosocial Assessment. R6s comprehensive care plan was updated to reflect assessment findings for trauma-informed care to support the resident's diagnosis of PTSD. On August 4-6, 2025, the Interdisciplinary Team (IDT) conducted a comprehensive review of all current resident records to verify completion of trauma-informed care assessments. For residents identified with a history of post-traumatic events, individualized care plans were reviewed and/or developed to address and support their specific trauma-related needs. Trauma-informed care education will be reviewed during the nursing team meeting scheduled for August 13, 2025. The session will include an overview of the assessment process used to identify residents at risk for post-traumatic stress disorder (PTSD) and the development of care planning goals aimed at mitigating or reducing exposure to trauma-related triggers. Weekly audits will be performed for all newly admitted residents over a four-week period to verify completion of trauma-informed care assessments and care planning. If compliance is consistently upheld, the audit schedule will transition to a monthly frequency, pending further review and recommendations by the facility's QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245232	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood	503 HEARTWOOD DRIVE , CROSBY, Minnesota, 56441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0699 SS = D	Continued from page 4 time the facility was changing ownership and electronic medical records. Because of this, R6 was “missed”, and a trauma informed care assessment was not completed. The DON stated the assessment should have been completed for staff to identify and care plan triggers and interventions for R6’s psychosocial needs. The facility Trauma Informed Care Policy revised 12/22, identified the facility would ensure staff assessed a resident who displayed or was diagnosed with mental disorder or psychological adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder and facilitate appropriate treatment and services to manage the assessed problem to attain the highest practicable mental and psychological well-being. The intent of this requirement was to ensure that the facility delivered care and services which, in addition to meeting professional standards, were delivered using approaches which were culturally competent and account for experiences and preferences and addressed the needs of trauma survivors by minimizing triggers and/or re-traumatization.	F0699		